TO BE COMPLETED BY FUNERAL DIRECTOR

rurs after death. Page 6 may be retained by the hospital or attending physician,	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Debt; of Health and Mental Hydiene prior to burial, cremation, or removal.	nedical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the filed within 72 hours after death with the State Deot; of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

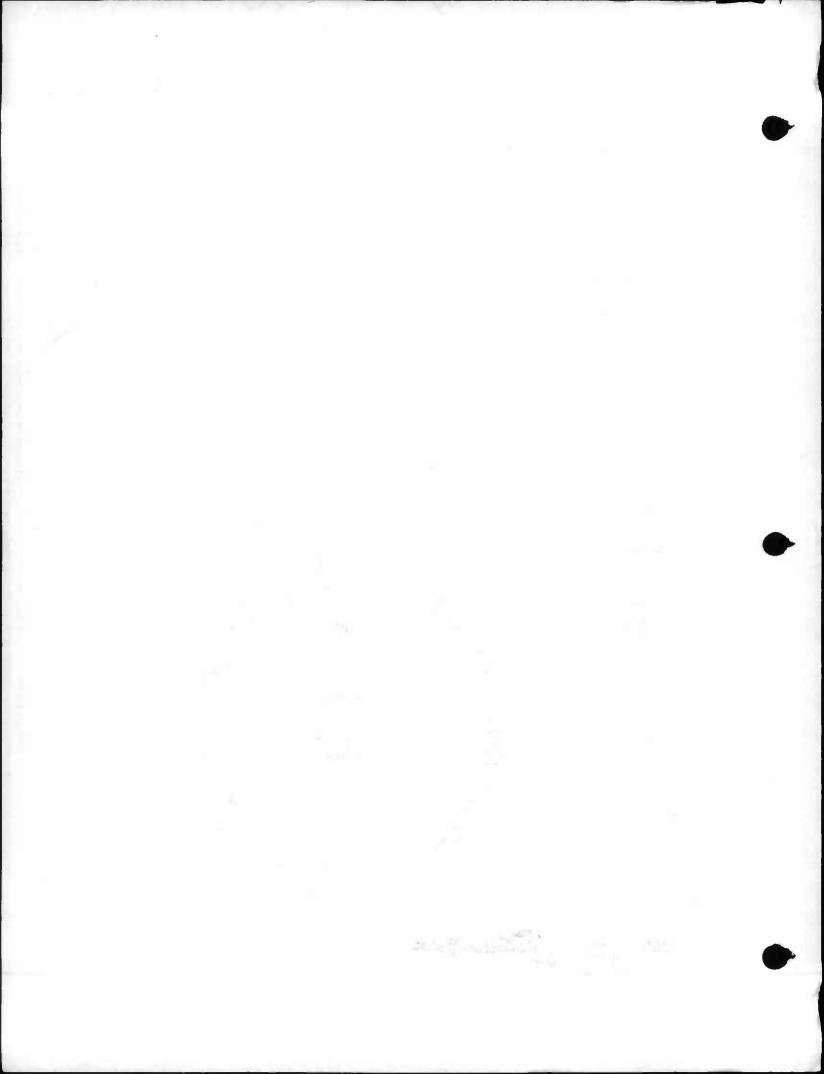
					0.0		
FOR 1 - STATE REGISTRAR	STATE OF MARYLAND /	DEPARTME	NT OF HEALTH AND TE OF DEATH	MENTAL HYGIEN	-	08501	
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH	
George A.	King			MONTH D		9- 18:58 PM	
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. le:		DER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign	
093-50-1730 9e. FACILITY NAME (If not institution, give s	1 № 2 □ F 34	YRS. MONTH		(Month, Day, Year) 3/12/59		New York	
St. Toseph A	tospitel	96. 0	Toward,	Md	Ba	of DEATH	
10a. STATE 10b. COUNTY		10c. CITY, TOW	N OR LOCATION			10d. INSIDE CITY	
	rie	Ham	burg			12 X YES 2 NO	
10e. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?	
4889 Winterway			14075		l ī	J.S.A.	
11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2	NO.	13. WAS DECENDENT OF HISPA If yes, specify Cuban Mexic	NIC ORIGIN? (Specify Ye	s or No— 14	I. RACE — American Indian, Black, White, etc.	
1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 TYES 2 AO Speci			Connibia a A / 1	
15, DECEDENT'S EDUC	PATION .					White	
(Specify only highest grade	completed) (G	ECEDENT'S USUAL Give kind of work do Do NOT use retige	ne during most of working	16b. KIND OF BU	SINESS/INDUS	STRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	pent	1	Com	put	u	
17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surnemp) 18. MOTHER'S NAME (First, Middle, Meiden Surnemp) 18. MOTHER'S NAME (First, Middle, Meiden Surnemp)							
19a. INFORMANT'S NAME (Type/Print)		b. MAILING ADDR	ESS (Street end Number or Rural	Route Number, City or Tow			
Mrs. Hilda King			as 10e		, , , , , , , , , , , , , , , , , , , ,		
20er METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Remote 4 Donation 5 Other (Specify)	Elmla	and DATE OF DISI	cal		more,	y or Town, State	
21. SIGNATURE OFFUNERAL SERVICE LIC	Madri de		22. NAME AND ADDRESS OF FA	1050 Y	ork Rd	. 21204	
23. PART I. Enter the diseases, pro	complications that caused the de	eath Do not en	Ruck Towson	Funeral H	ome, I	nc.	
shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Listonly one cause on each line		Tony a	erest.	iratory arrea	interval Between Onset and Death	
	PASSIBLE AS A CONSE	DUENCE OF	tex. In	las. t		2 4	
Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSE	QUENCE OF:	0 .	t.	-		
cause. Enter UNDERLYING	severe (emico	Smedul	lang in	Jel	nak 16 40	
CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSE	QUENCE OF):		8	4	1-7/	
resulting in death) LAST	Morgins	Sys	ndrome			1	
PART II. Other significant condition	s contributing to death but not	resulting in the	Underiving cause given in	Part I. 24a, WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS	
		23-9	3	PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
1				1 TYES	MO	OF DEATH?	
U						1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PLACE OF DEATN (C	heck only one)			
1 YES 2 NO	HOSPITAL: 1.2 Inputient 2 - ER/Outputient 3	DOA 4 1	IER: Nursing Nome 5 - Residence	8 Other (Specify)			
27. MANNER OF DEATN 1 ☑ Natural 5 ☐ Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE NOW	INJURY OCCU	RED	
2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY At he building, atc. (Specify)	Dme, farm, street,		281. LOCATION (Street City or Town, State)	and Number or	Rural Route Number,	

29b. SIGNATURE AND TIPLE OF CERTIFIED 29d. DATE SIGNED (Month, Day,

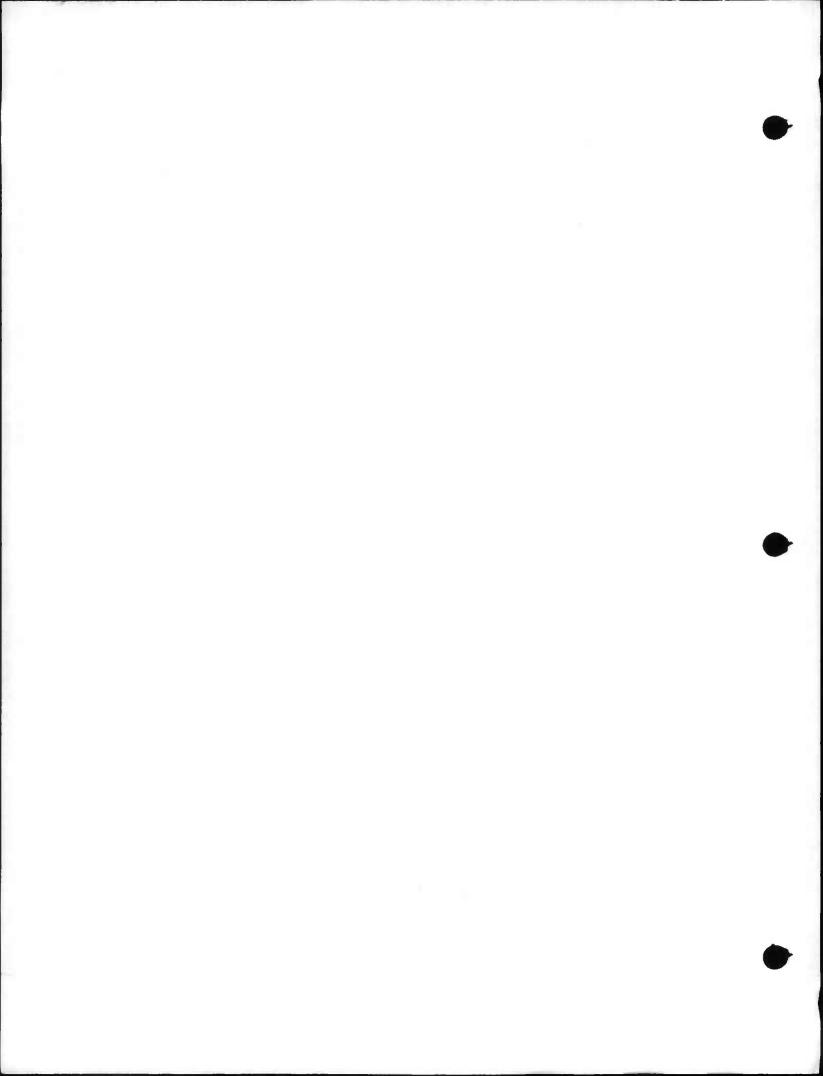
mg -21 585

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print)

MAR 3 0 1993



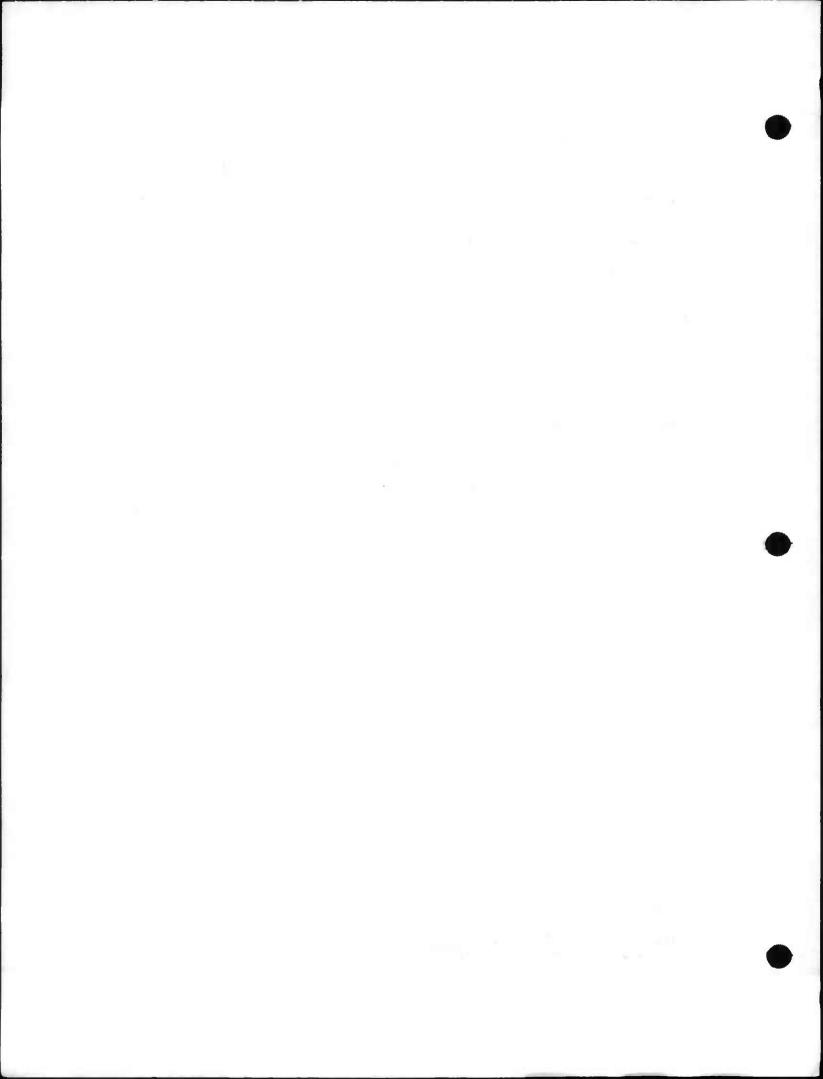
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Krel MONTIL 03 YEAR aura 11:55 R. MC A SOCIAL SECURITY NUMBER E SEY 6. AGE (In yrs. lest birthdey, IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 212-26-0923 1 M 2 F 96 10-4-1896 Maryland permit. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Howard County General Hospital Columbia Howard RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Towson 1 TES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 6502 Lock Hill Road rial-transit 21239 U.S. A. after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS . RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Ves or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married 1 TES 2 TO NO Specify COMPLETED BY White 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRO (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) page 5 should be detached for 8 Sales Clerk Department Store notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) George Richard Watts Jennie Rae Hettling BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Mrs. Carolyn W. Oueen 13225 Greenmount Avenue Beltsville, Maryland 20705 eg 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must 1 X Burial 2 Cremation 3 Ren
4 Donation 5 Other (Specify) director, Baltimore, Maryland 3/30 New Catherdal Cemetery 22. NAME AND ADDRESS OF FACILITY
Marzullo Funeral Service examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE the funeral michael 3981 Carrollton Road Upperco, Maryland 21155 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the attending physician and completely filled in by Mental Hygiene prior to burial, cremation, or remo Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition resulting in death) bue to (OR AS A CONSEQUENCE OF) reral executed within event. 10 Clery; SEPSIS OUE TO FOR AS A CO meinery traumatic MEDICAL CERTIFICATION Sequentially list conditions, QUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 23 shows any Injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY signed by the 1 YES 2 NO OF DEATH? 1 TES 2 NO has been s PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL The T 26. PLACE OF DEATH (Check only one) this certificate he havith the State D **EXAMINER?** HOSPITAL: OTHER 1 | YES 2 | YO 5 G Residence 6 G Other (Specify) 50 27. MANNER OF DEATH 28a. DATE OF INJURY 286. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Is marked, 1 Natural 5 Pending 1 YES 2 NO BY After 1 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED DIRECTOR: Jours after of 28 4 Homicide Item 29s. CERTIFIER
(Chack nnlv 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated FUNERAL (IMPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND THE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE 五五百 10 2019 C 3/ mi 23 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) MAR 3 0 1993 Fiche Devidson Pandell



physician.	The privat-transit permit. Pages 1, 2, 3 should)
HE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to use the material transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPI	TO THE FUNER be filed within	IMPORTANT:

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPA CERTI	RTMENT OFICATE	F HEALTH AND	MENT	AL HYGIEN					
	1. DECEOENT'S NAME (First, Middle, Last)						E OF OEATH			3. TIME OF C	EATH	
	_ ANNAM	MARIE KOELBLE				03		1993	/EAR	4:00	A	М
	4. SOCIAL SECURITY NUMBER		E (In yrs. lest birthday			7. DAT	E OF BIRTH nth, Day, Year)		BIRTH	PLACE (State of	or Foreign	_
	219-22-6750	1 M 2 X F	82 _{YRS.}	MONTHS D	WE HOURS MIN.		-1910		Country MAR	y YLAND		
	9a. FACILITY NAME (If not institution, give	street and number)		96. CITY, TO	WN OR LOCATION OF	DEATH		9c. COUNT	OF DE	ATH		
DIRECTOR	111 SHELLY ROAD			GLEN	BURNIE			ANNE	AR	UNDEL		
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TY.	100.0	TY, TOWN OR L	COATION							
SI	1	NNE ARUNDEL		EN BURN					- i	10d, INSIDE (
	10e. STREET AND NUMBER				10f. ZIP CODE			100 017175	1 05 11	1 TYES 2		_
FUNERAL	111 SHELLY ROAD				21061	L			S.A		* *	
S	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS	DECENDENT OF HISP	ANIC ORIG	IN? (Specify Ye	or No.— 14	BACE	— American I	Indian	
	1 Never Married 2 Married	FORCES? 1 YES		II ye	a, specify Cuban, Mexi YES 2/13/ NO Specific	cen, Puerte			Bleck.	Black, White, atc. Specify: WHITE		
Э ВУ	3XXWidowed 4 Divorced				NA.	,			фосп	, MUTI	. E	
COMPLETED	15. DECEDENT'S EOL (Specify only highest grad	JCATION e completed)	(Give kind o	'S USUAL OCCU	PATION g most of working	10	Sb. KIND OF BU	SINESS/INOUS	TRY			
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT	use retired.)								
N N	8TH	NONE	HOMEM	AKER			OWN H					
FRANK W. HARWOOD BARBARA WINTERS												
2	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Burel Route Number, City or Town, State, Zip Code) 111 SHELLY ROAD, GLEN BURNIE, MARYLAND 21061											
	20a METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	noval from State C6	b. PLACE AND DAT emetery, cremetory or MOST HOL			3/	20	CATION — CH			MD	
	21. SIGNATURE OF FUNERAL SERVICE LI		MOST HOL		E AND ADDRESS OF		931 BA	LITMOR	E ,	MAKILA	מאז	_
	1 anue 1	1	beix		GLETON FU		L HOME					
-4		1		1 5	ECOND AVE	. s.	W. GLE	BURN	ΙE,	MD 21	061	
	23. PART I. Enter the diseases, or shock, or heart failura.	complications that cause List only one cause on	ed the death. Do aach lina,	not enter the	moda of dying, su	ich as ce	rdiec or resp	ratory arres	t,	Approx	imate Betwe	
					1 . /		7	A			and De	
	disease or condition resulting in death)	· Reret	15010	- 2cc	-lant	760	ن رهد	~ · ·				
		DUE TO (OR AS	A CONSEQUENCE	OF):								
ON	Sequentially list conditions,	b	A CONSEQUENCE	0.00								
ATI	if any, leading to immediate cause. Enter UNDERLYING	DOL TO (OH AS	A CONSCOUENCE	OF):						i		
윤	CAUSE (Diseese or Injury that initieted events	C. DUE TO (OR AS	A CONSEQUENCE	OF):								_
CERTIFICATION	reaulting in death) LAST	4		,						İ		
		0.								+		_
Ä	PART II. Other significent condition	ns contributing to deeth	but not resulting	In the under	lying ceuse given i	n Part I.	24a. WAS AN PERFOR			WERE AUTOPS		is
8	Decoping	1					1 TYES 2	□ NO	1	COMPLETION DE DEATH?		
¥	trac tue	21705							1	1 _ YES 2 (□ NO	
ä												
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	6. PLACE OF DEATH (C	Check only o	one)					_
ΙλS	1 VES 2 NO	1 Inpetlant 2 ER/Out		4 - Nursing	Home 5 1 Residence	8 🗆 011	er (Specify)					
	27. MANNER OF DEATH T Natural 5 Pending	(Month, Day, Year)	26b. TI	JURY	INJURY AT WORK?	28d. DE	SCRIBE HOW I	NJURY OCCUP	ED			
B	2 Accident Investigation	OR DI ACE OF IN HIS			YES 2 NO							_
8	Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJUR building, atc. (Spe	ecify)	, streel, factory,	office		CATION (Street & y or Town, State)	and Number or	Rurei Ro	oute Number,		
山	29a, CERTIFIER											
릴	(Check only	ICIAN: To Jhe best of my know										
COMPLETED	2 MEDICAL EXAMINE	ER: On the beals of examination	on and/or investigat	lon, in my opinio	on, death occured at It	e time, dat	and place, en	d dua lo the c	ause(s)	and manner a	s stated.	
H H	29b. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE N	JMBER		29d. DATE S	GNED (Month, Day, Yo	er)	_
0	1 mero mero	orell			1111)(7		RE	0/1		
	30. NAME AND ADDRESS OF PERSON WH		, , , , , , , , , , , , , , , , , , , ,									
	DR. ROBERT B. KRC	OPNICK, M.D.	795 AQI	JAHART	RD. SUITE	203	, Glen	Burnie	,MI	210	61	
	31.MAR 3 0 1993	Fulla Day doon - A	indete									



1 - FOR STATE REGISTRAR	STATE OF MARYL	CERTIF	RTMENT OF		D MENTA	AL HYGIEN REG. NO	IE .	3 (18504
1. DECEDENT'S NAME (First, Middle, Last) A A A SOCIAL SECURITY NUMBER	KWAR	TA	KWARTA		MON	of DEATH	Y 21 9	93 3. YEAR	TIME OF DEATH
217-20-9744	1□M2 MF 96	(In yrs. last birthday) YRS.	# UNDER 1 YEAR MONTHS DAYS	# UNDER 24 HR	. (Mor	e OF BIRTH with, Day, Year) - 3 - 9 6		Country) MAR	ACE (State or Foreign
9a. FACILITY NAME (If not institution, give str EASTPUINT NURS) RESIDENCE OF DECEDENT				ALTIM			9c. COUNT		MORE
MARYLAND BALT	IMORE		Y, TOWN OR LOC BALTIM						Id. INSIDE CITY LIMITS? X YES 2 NO
100. STREET AND NUMBER 7410 POPLAR AVE			1	01. ZIP CODE 21224				S A	T COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	If yes, s	CENDENT OF HIS specify Cuban, Max S 2 NO Spe	tican, Puerto	N? (Specify Yes Ricen, etc.)	or No- 1	4. RACE — Black, W Specify: WHI	American Indian, /hita, etc.
15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) 6 YAERS	ATION completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of life. Do NOT us) HOMEM	work done during n se retired.)	TION nost of working	16	b. KIND OF BU	SINESS/INDU		I E
17. FATHER'S NAME (First, Middle, Last) JOHN STACHLINS	KI			ANN	٩	Middle, Maiden			
199. INFORMANT'S NAME (Type/Print) MRS. ANNA PETRO	CCARO	196. MAILING SAMI		and Number or Rui	ral Route Nun	nber, City or Tow	n, State, Zip C	ode)	
20a, METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Removed 4 Donetion 5 Other (Specify)	val from State cen	netery, cremetory or o	OF DISPOSITION (F ther place) ISLAUS	CEMETE	ERY3-	1E 20c. LO	LTO.		
21. SIGNATURE OF FUNERAL SERVICE LIG	Leseme	die	KACZ	OROWSKI FLEET	FACILITY I FUN	NERAL	HOME		224
23. PART 1. After the diseases, or control of the c		ech line.	ONIA	ode of dying, s	uch es cer	dlec or respi	ratory arres	et,	Approximete Intervel Between Onset and Deat
Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST		CONSEQUENCE OF							
PART II. Other significant conditions Life CVA Livery to	contributing to death b - Atua		n the underlyin		In Part I.	24a. WAS AN PERFOR 1 YES 2	MED?	CO OF	RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
1 VES 2 ANO	HOSPITAL: 1 Inpatient 2 ER/Outp	entient 3 DOA	OTHER:	LACE OF DEATH					
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident investigation	28e. DATE DF INJURY (Month, Day, Yeer) 28e. PLACE OF INJURY		M 1	JURY AT ORK? YES 2 NO		SCRIBE HOW IP			
3 Suicide 6 Could not be detarmined	building, etc. (Spec	ofy)			City	ATION (Street a or Town, State)			Number,
	AN: To the best of my knowl On the besis of examination								d manner ee stated.
286. SIGNATURE AND TITLE OF CERTIFIER	a all	01.		29c. LICENSE N	UMBER		29d. DATE S	IGNED (Mo	nth, Day, Year)

I CRANBROOK Rd - COCKEYS VILLE, Md. 21030

TO THE HOLD TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FLY After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be, filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. WISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020

0

BIENVENIOÙ R. MAT 31. MARED (MONTH, Dev. 1981) 31. MAR 3 0 1993 Jul

32. RÉGISTRAR'S SIGNATURE

	1	FOR STATE REGISTRAR	STATE OF MARYL			ENT OF H		MENTAI	REG. NO.		
		DECEDENT'S NAME (First, Middle, Last)	KRYS	>14	1K			2. DATE MONTE	of DEATH	(TEAR 1. TIME OF DEATH
pino	Ľ	I. SOCIAL SECURITY NUMBER 2 9-50-6344 De. FACILITY NAME (If not institution, give str	12 F 45	(In yrs. lest	YRS. MO	UNDER 1 YEAR ITHS DAYS	HOURS MHI.	(Month	OF BIRTH 1, Day, Year) 28/48	9c, COUNTY	Country) MD •
2. 3 sh	(hurch Hosp	ital Corr	6/4		Bal	tino	re	ity	SC. COUNTY	OF DEATH
020 physician. burial-transit permit. Pages 1, 2, 3 should 7 FUNERAL DIRECTOR		MD .				OWN OR LOCATION OF					10d. INSIDE CITY LIMITS? XX YES 2 \(\square\) NO
20 vysician. urial-transit permi		607 S. LINWOOI	AVE.			10f.	21224			_	N OF WHAT COUNTRY?
B # B	1	1. MARITAL STATUS Never Married 2 Married Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D.	2/ VN		If yes, spe	NDENT OF HISPAN city Cuban, Mexica NO Specify	n, Puerto I	? (Specify Yes lican, etc.)	or No 14.	Black, White, atc. Specify: WHITE
od for u		15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)		(Gh	re kind of work Do NOT use re	AL OCCUPATION done during mos ired.)	N t of working	16b.	KIND OF BUSI	INESS/INDUS	TRY
> ≥ ≥ ≥ m		7. FATHER'S NAME (First, Middle, Last) JOHN A. KRYS	SIAK	<u> </u>	100110		18. MOTHER'S NAME THE		Middle, Maiden S A SAPI		
MAR retained 5 should notified		MARY ELLEN KRY	YSIAK	19b.	MAILING AD	DRESS (Street and	d Number or Rural F	Bi	ALTO.	State, Zip Co	21224
ORE, e 6 may be rector, page	1	0a. METHOD OF DISPOSITION Burlel 2 Cremation 3 Remo Donation 5 Other (Specify)	val from State Cen	etery, cren	ND DATE OF D natory or other ROSA	SPOSITION (Name of the lace)		4/0			y or Town, State
BALTIMORE, ter death. Page 6 may be the funeral director, page oval.	1	1. SIGNATURE OF FUNERAL SERVICE LICE				22. NAME AND	ADDRESS OF FAC		р п	101 0	G. CHESTER ST
In 24 hours at ely filled in by nation, or rem		23. PART I. Enter the diseases, or construct, or heart failure. Limited MMEDIATE CAUSE (Final disease or condition resulting in death)	emplications that caused lat only one cause on e	ach line.	TA	LUR	e of dying, such	h as card	lac or respin		
P.O. BOX 687/ h certificate be executed anding physician and con Hygiene prior to burial, or other traumatic er		Sequentially list conditions, f any, leeding to immediate sause. Enter UNDERLYING CAUSE (Disease or injury hat initiated events esuiting in death) LAST	DUE TO (OR AS A	CONSECU	UENCE OF):	S C F	LEOF	102	(5)		Years.
RECORDS equires that the on signed by the of Health and Me hows any Inju MEDICAL		PART II. Other eignificant conditione Pewal WSA Gastromers	contributing to death b		sulting in t	ne underlying	cause given in	Part I.	24s. WAS AN A PERFORM 1 YES 2	AED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AN 23 as I	2	5. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		0	26. PL/	ICE OF DEATH (Che	ock only on	0)		
~ ~ ~ ~ .	2	7. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	1 Department 2 ER/Outp 28s. DATE OF INJURY (Month, Day, Year)	atient 3 [28b. TIME OF	28c. INJU WOR	S Residence RY AT IK? ES 2 NO		(Specify) CRIBE HOW IN	JURY OCCUR	NEO
SI CEND		3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At hom	ne, farm, stree	t, factory, office		28f. LOC	ATION (Street ar or Town, State)	nd Number or i	Rural Route Number,
	2		IAN: To the best of my know : On the besis of examination								surse(s) and manner as stated.
TO THE HOSPITAL TO THE FUNERAL DE find within 72 IMPORTANT: II	L	BIGNATURE AND TITLE OF CEATIFIER D. NAME AND ADDRESS OF PERSON WHO	koma?	30	5	M.D.	29c, LICENSE NUM	置 子	37	29d. DATE SI	AGNED (Month, Day, Year)
	L	17 - 1	COMPLETED CAUSE OF DE	MD	CH+	urch	HOSP.	4	SACT	5 V	MD
	Ĺ	MAR 3 0 1993	Julia Davidson		dell						DHMH-16 Rev 1/89

y management of the contract of TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN.

TO THE FUNERAL DIRECTOR: After this certificant the death certificate be executed within 24 yours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificant to the strength of the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Sam Drop. of the strength of the stren TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

REGISTRAR		CERTIFIC	AIE OF	DEATH	REG. NO		
1. DECEDENT'S NAME (First, Middle, Last)	LYLES	1			2. DATE OF DEATH DO NORTH DO N	¥ 9 .	
4. SOCIAL SECURITY NUMBER 216-62-1864	5. SEX 6. AGE (I		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day Year)	G	HRTHPLACE (State or Foreign ountry)
9a. FACILITY NAME (If not institution, give str	-) ab	CITY TOWN	OR LOCATION OF DE		9c. COUNTY C	OF DEATH
UNION MEMORIAL	- Hospital	90		MORE	AIR	SC. COUNTY	A DEALY
RESIDENCE OF DECEDENT		I transport					I
MAYUMAY 106. COUNTY		10c. CITY, TO	OWN OR LOCA	nore			10d. INSIDE CITY LIMITS? 1 YES 2 NO
10e. STREET AND NUMBER	1	1	10	t. ZIP COOE		10g. CITIZEN	OF WHAT COUNTRY?
2924 CARD	12. WAS DECEDENT EVER IN	J A DIAED	12 WHO DE	2/20	25 IIC ORIGIN? (Specify Yes	U.	RACE — Amarican Indian,
1 Never Married 2 Married	FORCES? 1 YES	2 NO	It yes, sp	ecify Cuban, Maxica	n, Puarto Rican, atc.)	14.	Black, White, etc.
3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES	1 TYES	Specify	r.		B/ACK
15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	16a. DECEDENT'S USI (Give kind of work	done during me	ON ost of working	18b. KIND OF BU	SINESS/INDUST	RY
Elementary/Secondary (0-12)	College (1-4 or 5+)	Disabil	etired.)				
17. FATHER'S NAME (First, Middle, Last)		DISQUIT	LLY	18. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)	
Norman M. Lyles	<u>.</u>			Marceler	ne Sweet		
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street	and Number or Rural	Route Number, City or Tox	n, State, Zip Code	(e)
Mrs. Marcelene Davis		2924 Carv	er Rd.	Baltimore.	Md. 21225		
20a. METHOD OF DISPOSITION	206	PLACE OF DISPOSITION Of the place)	ON (Name of ce	metery, cremetory or	20c, LC	CATION - City	or Town, Stata
4 Donation 5 Other (Specify)	()	Arrison	, For	rest the	Cons 6	14/10.	. Co. Ind.
21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22/NAME A	ND ADDRESS OF FA	900155 F	UNEN	Al Home
* Joseph	J. Kuss		222	2411	orth Ave	BAL	5 And 21216
23. PART i. Enter the diseasea, or o			enter tha m	oda of dying, suc	h as cardiac or reap	Iratory arreat,	
shock, or haart fallure.	Liat only ona cause on a	ach lina.					Intarval Between Onset and Dasth
disease or condition	HEMOIR	RHAGE /	HUPG	VULFM!	A		12 HOVES
resulting in death)		CONSEQUENCE OF):	1) 119		,		1,00,10
	UPPE	291 8	SLEE	D			ZHURS
Sequantially list conditions, if any, leading to immediate		CONSEQUENCE OF):	" Y				11 6
cause. Enter UNDERLYING CAUSE (Disease or Injury	2.	for ARIV	5-				16MS
that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
Tesulang in death) Exst	ı						
PART ii. Other algolificant condition	s contributing to death b	ut not resulting in t	tha underlyir	ng cause given in		AUTOPSY RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
					1 YES	2 🗆 NO	COMPLETION OF CAUSE OF DEATH?
						j	1 TYES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. F	PLACE OF DEATH (Ch	eck only one)		
1 X YES 2 NO	1 Inpatient 2 ER/Outp			me 5 🗆 Realdence	a ☐ Other (Specify)		
27. MANNER OF DEATN	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME C		JURY AT ORK?	28d. DESCRIBE NOW	INJURY OCCUR	ED
1 Natural 5 Pending 2 Accident Investigation			M 1 🗆	YES 2 NO			
3 Suicide 8 Could not be 4 Nomicide detarmined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, stre	et, tactory, offi	ce	28t. LOCATION (Street City or Town, State		lural Route Number,
29a. CERTIFIER			weet				
(Check only CERTIFYING PHYSI	CIAN: To the best of my know R: On the basis of examination			•	* *		euse(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIED	3			29c. LICENSE NU	MBER	29d. DATE SI	GNED (Month, Day, Year)
Thanker	~ m			0771	127	1 3	24/92
30. NAME AND ADDRESS OF PERSON WH		ATH (ITEM 27) (Type, Pr	rint)	woj	7		- 1 1 2
JOHN WOGAR	1 . M. D 1			EIML H	OSPITAL	BAUT	IMARE MD.
MAR 3 0 1993	hi Desider	pane					

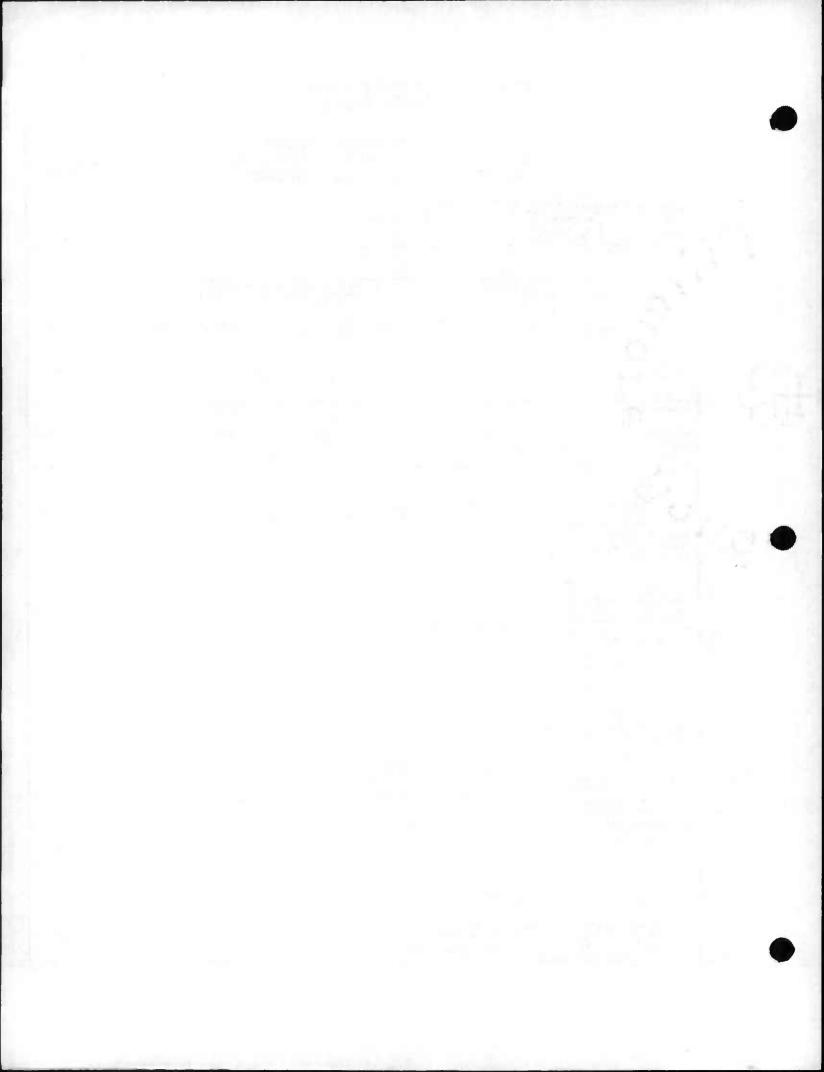


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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attri	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
JOSP!	UNER	ithin	ANT
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	1 • FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM			MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last) William		Torran			2. DATE OF DEATH DA		3. TIME OF DEATH
		s. SEX 8. AGE (In	Lawrence	UNDER 1 YEAR	IF UNDER 24 HRS.	March 29		HPLACE (State or Foreign
	EIL 10 7001	1 X M 2 □ F 85	YRS.	NTHS DAYS	HOURS MIN.	8/26/07	Coun	ryland
	9e. FACILITY NAME (If not institution, give street		96	a. CITY, TOWN OR	LOCATION OF DE	ATH	9c. COUNTY OF	HTAB
СТО	Calvert Memorial	Hospital			Frederic	k	Calve	ct
DIRECTOR	Maryland Calver	`t		peake B				10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	106. STREET AND NUMBER 8314 E. Street				732		_	WHAT COUNTRY?
R		2. WAS DECEDENT EVER IN	110 401150				United	
ΒY	1 Never Married 2 X Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 ND	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 ND Specify:				E — American Indian, k, Whita, etc. //y: White
ETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	rion mpleted)	16a. DECEDENT'S USI (Give kind of work	UAL OCCUPATION done during most dired.)	of working	16b. KIND OF BUS	INESS/INDUSTRY	200
PE	Elementary/Secondary (0-12)	College (1-4 or 5 +)	lanufactor			Welding	Equip.	
COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAN	NE (First, Middle, Maiden S	Sumame)	
BE C	James A. Lawrence				Lottie S		,	
6	190. INFORMANT'S NAME (Type/Print) Mrs. Frances B. Lav	vrence				oute Number, City or Town		
	20s. METHOD OF DISPOSITION	20h F	ACE AND DATE OF D	ISBOSITION /Nom	of		ATION — City or T	own State
	1 V Burlei 2 Cremation 3 Remove 4 Donation 8 Other (Specify)	rom State Come	tery, crematory or other CKWOOD CE	metery	3/31	/93 Balt	imore,	
	21. SIGNATURE OF FUNERAL SERVICE LICEN Mark T.			22. NAME AND	J. RUC			
	Mark 1.	"Lawyra		15305 Ha	arford R	oad Balti	more, Mi	21214
	23. PART i. Enter the diseases, or cor abook, or heart failure. Lis iMMEDIATE CAUSE (Final disease or condition resulting in death)	CONS O	ch line.		eart-		'ne	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	5/8	CONSEQUENCE OF):	\	My	ocardi whon	20	1/28/93
PHYSICIAN: MEDICAL C	PART II. Other algnificent conditions of	contributing to death but	t not reculting in t	he underlying	Cause given in F	Part I. 24a. WAS AN / PERFORI	MED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ND
CIA		IOSPITAL:	O	26. PLAC	CE OF OEATH (Che	ck only one)		
17S	1 VES 2 NO 1	□ Inputient 2 □ ER/Output 28a. OATE OF INJURY	Sent 3 DOA 4	Nursing Home	-	Other (Specify)		
ву Р	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME OF	M 1 YE	(7	28d. DESCRIBE HOW IN	JURY OCCUREO	
	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY – building, atc. (Specify	At home, farm, stree	t, factory, offica		281. LOCATION (Street as City or Town, State)	nd Number or Rural	Route Number,
COMPLETED	2001	IN: To the best of my knowled On the bests of exemination of						s) and manner as stated.
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	1	22 30	1	Pe. LICENSE NUM		29d. DATE SIGNED	
TO B	1. VI. 6. SI	refor 1	7.0.		0-2	2634	3-2	9-93.
	30. WAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEAT			erick, M	Maryland		20678
	31. DATE FILES (MONTH, Day, Year) MAR 3 0 1993	32 REGISTRAR'S SIGNAT	UDF					

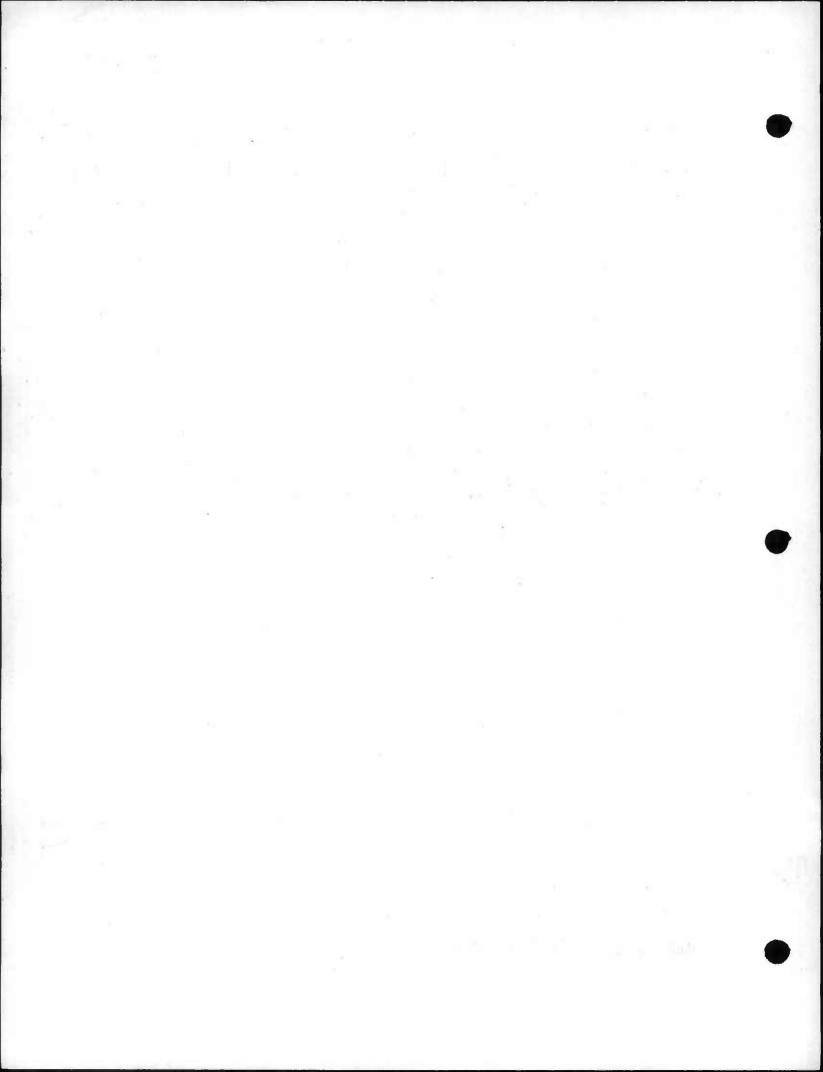


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PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 shou	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	the medical examiner must be notified at once
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law I	TO THE FUNERAL DIRECTOR: After this certificate has be	be filed within 72 hours after death with the State Dept.	standarts. H Hom 28 is marked or Hem 22 s

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	nedistrian			L OI DEMIII	ned. N	0.				
	1. OECEDENT'S NAME (First, Middle, Last)	10	1	6	2. DATE OF DEATH MONTH	DAY	YEAR 3. TIME OF DEATH			
	-	ydia	Lync	X)	3 2	7 9	3 10 cm"			
	4 . 4 . 14	6. SEX 6. AGE (In yrs. II	YRS. IF UNDE	DAYS HOURS M	IN. (Month, Day, Year)	04	BIRTHPLACE (State or Foreign Country)			
	210 11 0133		7000	Y TOWN OR LOCATION	6-1-18	93	My			
Œ	96. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH 86. HIMORY 86. HIMORY									
5	RESIDENCE OF DECEDENT	us center K	AND ASKONIA			1001-	imord			
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY, TOWN	OR LOCATION	<u> </u>		10d. INSIDE CITY LIMITS?			
	MY		1 Ba	(10			YES 2 NO			
1AI	100. STREET AND NUMBER	1: 5+		10f, ZIP CODE		10g. CITIZI	EN OF WHAT COUNTRY?			
FUNERAL	124 W. Frank			2/20			UISIA			
	11. MARITAL STATUS 1: 1 Never Married 2 Married	2. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2		If yes, specify Cuban, N	ISPANIC ORIGIN? (Specify exican, Puarto Rican, atc.)	Yea or No-	4. RACE — American Indian, Black, White, atc.			
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	`	1 VES 2 NO	Specify:		specify: Black			
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highes) grade con		DECEDENT'S USUAL	OCCUPATION during most of working	16b. KIND OF	BUSINESS/INDU	STRY			
H	T	College (1-4 or 5+)	fe. Do NOT use retired.)						
MP										
8	17. FATHER'S NAME (First, Middle, Leel)	1.		16. MOTHER	S NAME (First, Middle, Maid	en Surname)				
BE	Ervin Moa	,-		1/104	y Hms	trong				
9	19a. INFORMANT'S NAME (Typo/Print) Albert Rings	old	632	Reckford	Rufel Route Number, City or I	Li Kun	nd 21047			
	20a, METHOD OF DISPOSITION 1 Burlel 2 Cremellon 3 Remova 1 Donation 5 Other (Specify)	al from State 20b. PLAC	E OF DISPOSITION (P	Published Completery, cremato	Pay 20c	LOCATION - C	ity or Town, State			
	21. SIGNATURE OF FUNGAAL SERVICE LICEN	WSEE /	22	NAME AND APPRESS	OF FACILITY	at it.	14			
	* Hala	March		Jack 3	00 was	ach	Ane			
1	23. PARP I. Enter the diseases, or cor	mplications that caused the est only one cause on each lie		er the mode of dying	such as cardiac or re	spiratory arre	st, Approximate Interval Between			
	IMMEDIATE CAUSE (Finel	st only one cause on each m	rei.		21. 2		Onset and Death			
	disease or condition resulting in death)	Brandel	hade C	adene	alforen	-00				
	CONTRACTOR AND	DUE TO (OR AS A CONS	EQUENCE OF):	0	ASI					
ON	Sequentielly list conditions,	DUE TO (OR AS A CONS	BOURNOR OFF	سيروس						
Y.	If sny, lasding to immediata cause. Enter UNDERLYING	52500000000000000								
FI	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A CONS	EQUENCE OF):							
CERTIFICATION	resulting in desth) LAST									
	PART II. Other significent conditions	contributing to death but no	t resulting in the t	inderlying ceuse give	on in Part I. 24a. WAS	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS			
EDICAL			.00-10-50-0	13504-14-150-14-1		ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
ED						2 110	OF DEATH?			
7							1			
IAN	25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEAT	H (Check only one)					
PHYSICIAN:		HOSPITAL: 1 Inpatient 2 ER/Outpatient	3 DOA 4 DA		ence 6 Other (Specify)					
Ĭ	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?	28d. DEŞCRIBE HO	W INJURY OCC	JRED			
	1 Nitural 6 Pending		М	1 YES 2 N	0					
	2 Accident Investigation		home form street fo	ctory, office			or Rural Route Number,			
BY	3 Suicide 6 Could not be	28e. PLACE OF INJURY — At building, etc. (Specify)	riome, tariti, ectoec, te		City or Town, St					
BY	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or lown, St					
BY	3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only	building, etc. (Specify) AN: To the best of my knowledge,	death occurred at the		d due to the cause(e) and	manner aa state				
BY	3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only	building, etc. (Specify)	death occurred at the		d due to the cause(e) and	manner aa state				
COMPLETED BY	3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only	building, etc. (Specify) AN: To the best of my knowledge,	death occurred at the		d due to the cause(e) and at the time, data and place	manner as state				
BE COMPLETED BY	3 Sulcide 4 Homicide 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	AN: To the best of my knowledge, On the basis of examination and/o	death occurred at the	opinion, death occured	d due to the cause(e) and at the time, data and place	manner as state	cause(a) and manner as stated.			
COMPLETED BY	3 Suicide 4 Homicide 6 Could not be detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	AN: To the best of my knowledge, On the basis of examination and/o	death occurred at the	opinion, death occured	d due to the cause(e) and at the time, data and place	manner as state	cause(a) and manner as stated.			
BE COMPLETED BY	3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	AN: To the best of my knowledge, On the basis of examination and/o	death occurred at the prince of the prince o	opinion, death occured	d due to the cause(e) and at the time, data and place	manner as state	cause(a) and manner as stated.			
BE COMPLETED BY	3 Sulcide 4 Homicide 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	AN: To the best of my knowledge, On the basis of examination and/o	death occurred at the prince of the prince o	opinion, death occured	d due to the cause(e) and at the time, data and place	manner as state	cause(a) and manner as stated.			



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FOR STATE REGISTRAR

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I. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN MARCH 0840 AM LILLIE BROWN LEWIS 2 1993 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 12-10-02 IF UNDER 1 YEAR IF UNDER 24 HRS s. BIRTHPLACE (State or Foreign DAYS HOURS Chesterfield, Va 1 M 2 F 90 VDE 230-01-9304 uted within 24 hours after death. Page 6 may be retained by the hospital or attending physician. completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should rial, cremation, or removal. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE UNION MEMORIAL HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDEN 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 700 W. 40th Street 21211 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yee, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, alc. 1 Never Married 2 Married ΒY 3 Widowed 4 Divorced **Black** COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Housewife 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) te George W. Brown Mary F. Brown BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Idella Gray 3820 Kilburn Randalstown, Md. pe 20a. METNOD OF DISPOSITION 20c. LOCATION — City or Town, Slate 20b. PLACE AND DATE OF DISPOSITION (Name of must 1 Buriel 2 Cremation 3 Removal from State Union Branch Bapt. Ch. Cem. 4 Donation 5 Other (Specify) Chesterfield, Va. examiner 22. NAME AND ADDRESS OF FACILITY William C. Brown Funeral 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 1206 W. North Ave. Balto. Md. #17 Home medical 23. FART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart feliure. List only one cause on sech line. interval Between IMMEDIATE CAUSE (Fine) Onset and Death the disease or condition Dira DUE TO (OR AS A CONSEQUENCE OF) resulting in death) traumatic event, the death certificate be executed the attending physician and con Mental Hygiene prior to burial, DUE TO (OR/AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING ema other t CAUSE (Disease Dr injury that initiated events resulting in death) LAST 0 Injury, PART II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY has been signed by t Dept. of Health and апу 1 TYES 2 LACT OF DEATH? shows 1 TES 2 NO PHYSICIAN: AW. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) OR ATTENDING PHYSICIAN: The this certificate h HOSPITAL OTHER: 1 YES 2 NO 1 Uripatient 2 ER/Outpatient 3 DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 0 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, 1 Diffatural 5 Pending Investigation 1 YES 2 NO ВY After 2 Accident 28a. PLACE OF INJURY — At home, farm, streel, factory, offica building, stc. (Specify) TO THE HOSPITAL OR ATTENDIN
TO THE FUNERAL DIRECTOR: Aff
be filed within 72 hours after dei
IMPORTANT: If Item 28 Is I 3 Suicida 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 8 Could not be determined COMPLETED 4 Homicide 29s. CERTIFIER
(Check only 1 CERTIFYING PNYSICIAN: To like best of my knowledge, death occurred at the lime, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 3/26 sukingham 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) INGHAM DO UNION MEMORIAL HOSPITAL MARION

32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

93

9c. COUNTY OF DEATH

10g, CITIZEN OF WHAT COUNTRY?

USA

3. TIME OF DEATH 24-01184AM

10d. INSIDE CITY

RACE — American Indian, Black, White, etc.

Black

Approximate

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?

1 YES 2 NO

29d. DATE SIGNED (Month

Interval Between

Onset and Desth

1 YES 2 NO

REG. NO.

2. DATE OF DEATH MARCH Lemon Charles Ε. 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year)
6 - 27 - 59 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 | F DAYS HOURS 217-68-5270 YRS. 33 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 2447 Westport St. Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD Baltimore permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 2447 Westport turneral director, page 5 should be detached for use as the burial-transit 21230 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—It yes, specify Cuben, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married It yes, specify Cuben, Maxican, Puerto Ri 1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 10th Unemployed 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) Charles Lemon Grace Byrd 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Grace E. Lemon 2447 Westport St./Baltimore, MD 21230 96 METHOD OF DISPOSITION

| Murini 2 | Cremetion 3 | Removal from State
| Connection 6 | Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE THE ST Cedar Hill Cemetery Anne Arundel Co, MD examiner 21. SIGNATURE OF BUNERAL SERVICES ICENSEE 22. NAME AND ADDRESS OF FACILITY tied in by the ten, or removal. Wm.C. March F/H 1101 E. North Ave. medical or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one cause on each lina. IMMEDIATE CAUSE (Final signed by the attending physician and completely "se Health and Mental Hygiene prior to burial, cremation." 2 RENAL FAILURE disease or condition resulting in death) AID HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremati RTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, it DIVISION OF VITAL RECORDS, P.O. BOX 68760, OUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF GEATH 28e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 Netural 1 YES 2 NO B 2 Accident 28s. PLACE OF INJURY — At home, term, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as atsted. TO THE HOSPITAL OF THE FUNERAL D BE filed within 72 ho 2 - MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER Soutet Clay · Resident AS2438 528 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ST. ARNESS

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CATON AVE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

DECEDENT'S NAME (First, Middle, Last)



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n 1993

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YEAR

3. TIME OF DEATH

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8. BIRTHPLACE (State or Foreign

manang physician.	de Liber Burtal-transit permit. Pages 1,	
6 may be retained by the hospital on	tor, page 5 should be detached for un	
within 24 hours after death. Page (pletely filled in by the funeral direc cremation, or removal.	
the death certificate be executed	by the attending physician and com of Mental Hygiene prior to burial,	
HYSICIAN: The law requires tha	this certificate has been signed by the with the State Dept. of Health and N	
THE HOSPITAL OR ATTENDING P	THE FUNERAL DIRECTOR: After the filed within 72 hours after death v	

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21214 0020

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH CLIFFORD LUND 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 79 213 07 0941 YRS. Jan. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE 10c. CITY, TOWN OR LOCATION Maryland Anne Arundel Pasadena FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 336 Riverside Dr. 21122 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Never Married 2XX Married 1 TYES 2 TO NO В Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only high Elementary/Second 1.2 ndary (0-12) College (1-4 or 5+) Pipe Fitter be notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gustav Lund Victoria BE 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Deceding. MD 21122 19a. INFORMANT'S NAME (Type/Print) 5 Mary R. Lund 336 Riverside Dr., Pasadena, MD 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 1 M Burial 2 Cremation 3 Removal from State
4 Donation 6 Other (Specify) examiner must Glen Haven Memorial Park 3/27/93 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD anno medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or haart failure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition resulting in death) Respiratore OUE TO (OR AS A CONSEQUENCE OF Item 23 shows any injury, or other traumatic event, Luncer MEDICAL CERTIFICATION Sequentially list conditions, OUE TO (OR AS CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA me 5 - Residence 8 - Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 26c. INJURY AT WORK? is marked. 1 Natural 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide COMPLETED 8 Could not be 4 Homicide IMPORTANT: If Item 28 29a. CERTIFIER (Check only one) and the control of
Gross

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PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

29c. LICENSE NUMBER

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

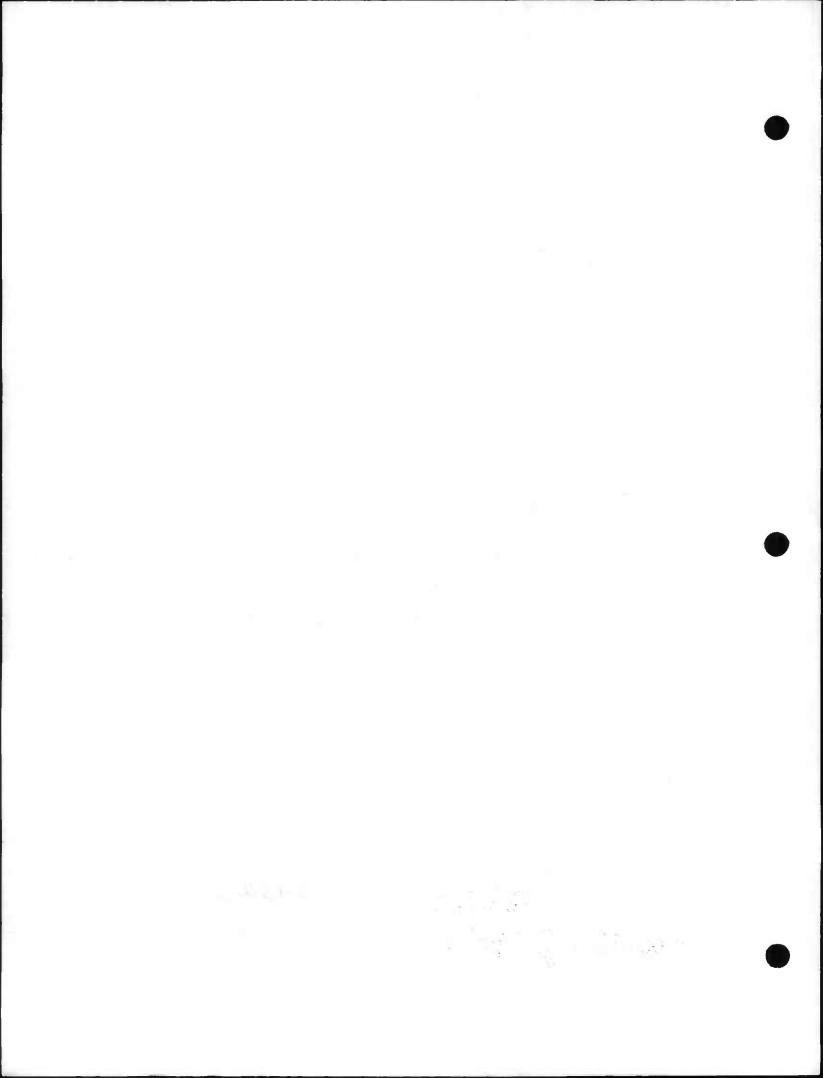
23,1914 Maryland 9c. COUNTY OF DEATH Anne Arundel 10d. INSIDE CITY LIMITS? 1 TYES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, etc. Specify: White 16b. KIND OF BUSINESS/INDUSTRY Ship Yard Stromberg OATE 20c. LOCATION -- City or Town, State Glen Burnie, MD 21122 Approximate Interval Between Onset and Death 8 hours 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF OEATH? 1 TYES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner as stated. 29d. DATE SIGNEO (Month, Day, 3-23-93 4330 E-ATKINSON M. D./780 RITCHIE HIGHWAY/SEVERNA PARK, MARYL

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29b. SIGNATURE AND TITLE OF GERTIFU



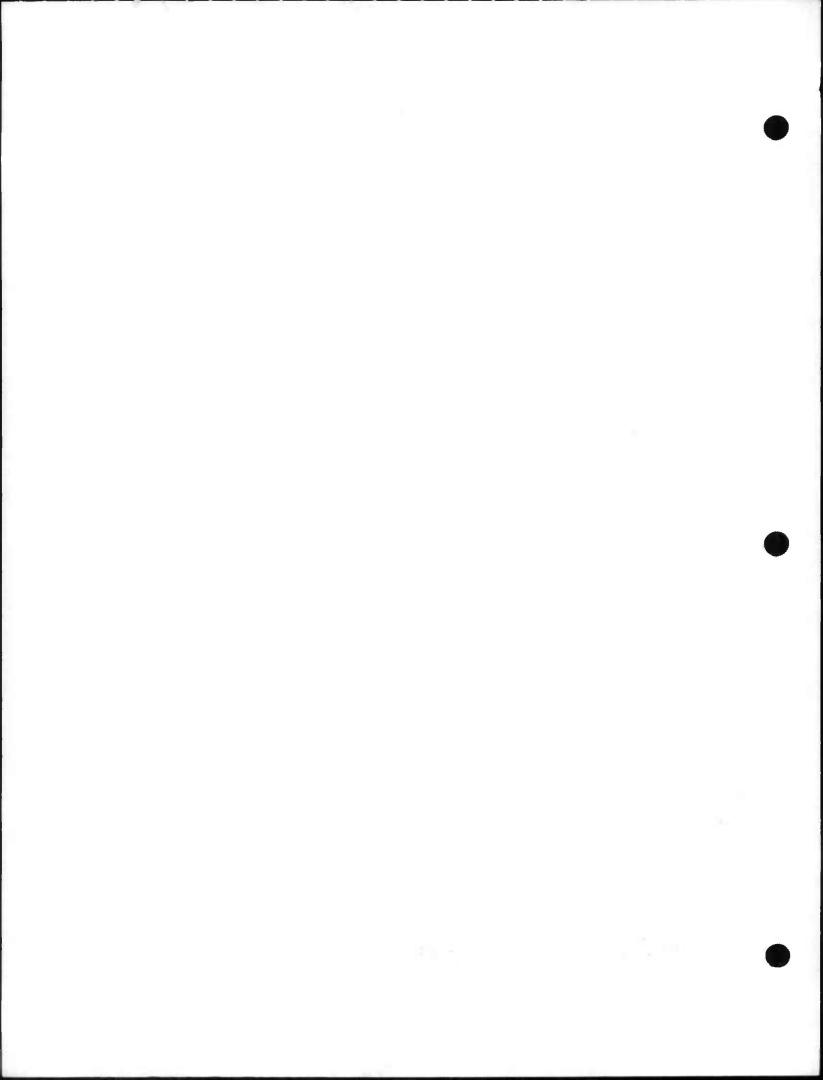
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DRATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3
be ned within 72 hours and with the State Uept. or Health and Merital Hygiene prior to bunal, cremation, or removal. IMPORTANT; If Item 8.5 practiced, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MAR 3 n 1993

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR s. sex Lamphere 3 1993 4. SOCIAL SECURITY NUMBER 26 6. AGE (In yrs, last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS 009-03-7212 1 M 2 KF 78 03-16-15 Vermont 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Glen Burnie, North Arundel Hosp Glen Burnie Anne ARundel RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? Anne Arundel Crofton 1 YES 2 NO 10e STREET AND NUMBER Crofton Conv. Center FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 21114 Reidel Road 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Mexican, Puerto Rican, stc.) 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, alc. If yes, specify Cuban, Mexican, Puerto R 1 Never Married 2 Merried BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16h. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Nurse Nursing 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) Arnold E. Preston Ida Wade BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jack Purves Marlboro Road, 682 Lothian, MD 20111-9633 26s, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION / Name of DATE 20c. LOCATION — City or Town, State 20a. METHOD OF Distribution 3 □ ↑ChBurlet 2 □ Cremation 3 □ 4 □ Donation 5 □ Other/Specify) Cemetery Davidsonville, MD Lakemont 21. SIGNATURE OF FRINCIS 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata ahock, or heart feilure. List only one cause on sech line. Intervel Between **IMMEDIATE CAUSE (Finel** Onset and Death disease or condition Pa osmola Diabetic Hei dosis resulting in death) Si6 /2 PHYSICIAN: MEDICAL CERTIFICATION Sequentieity list conditions, DUE TO (DR AS A CONSEDUENCE OF) If any, leeding to immediate cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (DR AS A CONSEQUENCE DF) that initieted events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 1 NO OF DEATH? 1 YES 2 1 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) HOSPITAL:
1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 1 YES 2 NO g Home 5 🗆 Residence 6 🗆 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending 1 YES 2 NO 8 2 Accident 28e. PLACE DF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide determined COMPLET 29a. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(a) and menner as attend. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner ee stated. 296. SIGNATURE AND TITLE DE CERTIFIE 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 29/93 24049 2 es of LETED CAUSE OF GEATH (ITEM 27) (Type, Print) 201 800 N Ham 2109 31, DATE FILED (Month Day Year)



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The requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

The standard by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be attended for use as the burial-transit permit. Pages 1, 2, 3 should be attended for use and the purial-transit permit. Pages 1, 2, 3 should be attended for use and the purial-transit permit. Pages 1, 2, 3 should be attended for use and the purial-transit permit. BALTIMORE, MARYLAND 21215-0020 RECORDS, P.O. BOX 68760, DIVISION OF WITH TO THE HOSPITAL OR ATTENDING PHYSICS TO THE FUNERAL DIRECTOR: After the Billed within 72 hours after dead was a MODERALT: If here 28 is not after

	1 STATE OF MA		RTMENT OF HEALTI CICATE OF DEA		NTAL HYGIENI REG. NO.	Ε	5.					
	1. Decement of the little thought Land		N McGOHAN	Made and the second	DATE OF DEATH DA		3. TIME OF DEATH					
Ting.	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHDL											
64	1 M 2 D E	YRS.	MONTHS DAYS HOURS	-	(Month, Day, Year)	1.3	BIRTHPLACE (State or Foreign Country)					
	9a. FACILITY NAME (If not institution, give street and number)	91 	9b. CITY, TOWN OR LOCA	TION OF DEATH	3/2/02	9c. COUNTY	Kentucky OF DEATH					
E E	ST. JOSEDA HA	CoitAl	TOW.	SOA		BA	CTIMORE					
DIRECTOR	RESIDENCE OF DECEDENT											
E E		10c. CN	Y, TOWN OR LOCATION		E .		10d. INSIDE CITY LIMITS?					
	Maryland Balto,		Towson	DE		10- CITIZEN	1 YES 2 NO					
FUNERAL	204 East Joppa Rd.			21 286		log. Officer						
3	11. MARITAL STATUS 12. WAS DECEDENT E	or No- 14.	RACE — American Indian,									
> 3 ☐ Wildowed 4 ☐ Divorced IF YES, GIVE WAR OR DATES 1 ☐ YES 2 🏅 NO Specify: Specify:												
												(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)
_ <u>_</u> _	12	Asst.	Vice Presid	lent	B. &	O. Rai	lroad					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				(First, Middle, Maiden		22000					
TO BE	James H. McGohan			Sar	cah	Α.	Mann					
2	19a. INFORMANT'S NAME (Type/Print)	196. MAILING	ADDRESS (Street and Numb	er or Rural Rout	e Number, City or Town	, State, Zip Coo	de)					
90	Robert R. Hager	_	Kilbride Ro	1. Ba	alto. Md.							
1971	20g, METHOD OF DISPOSITION 1	cemetery, crematory or o		2 (20			or Town, State					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Druid Ki	22. NAME AND ADDR	ESS OF FACILI	ту		le , Md.					
CXGIII	Monald (Schale fr.		Ruck Tows		1050 York eral Home							
355	23. PART i. Enter the diseasea, or complications that c shock, or heart failure. List only one cause	aused the death. Do	not enter the mode of d	ying, such a	a cardiac or respin	ratory arrest.	, Approximata interval Between					
	IMMEDIATE CAUSE (Final disease or condition	- · · c	0000	0			Onset and Death					
	resulting in death) - a. 301	R AS A CONSEQUENCE O	RECHIE	0	To							
2	- Ac	TE	RECATE ERITON	inic	2	any	t					
0	Sequentially list conditions, if any, leading to immediate	R AS A CONSEQUENCE O	F):				2					
S	CAUSE (Disease or injury	RFORA	TED	VIS	CUS.							
TIF	that initiated events DUE TO (OI resulting in death) LAST	R AS À CONSEQUENCE O	FI.									
CERTIFICATION	d.											
CAL	PART ii. Other significant conditions contributing to de	eth but not resulting	in the underlying cause	given in Par	t i. 24s. WAS AN A		24b. WERE AUTOPSY FINDINGS					
DIC					1 TYES 2		COMPLETION OF CAUSE OF DEATH?					
MEDI					-		1 [] YES 2 [] NO					
AN	25. WAS CASE REFERRED TO MEDICAL											
PHYSICIAN:	EXAMINER? HOSPITAL:	R/Outpatient 3 DOA	OTHER:	DEATH (Check								
Η	27. MANNER OF DEATH 28s. DATE OF IN.	JURY 28b. TIN			d. DESCRIBE HOW IN	JURY OCCUR	ED					
ВУ Р	1 Natural 5 Pending (Month, Day, 2 Accident Investigation	Year) IN	JURY WORK? M 1 TYES 2	□ NO								
	3 Suicide 8 Could not be 28e, PLACE OF II building, etc	NJURY — At home, farm, (Specify)	street, factory, offica	28	t. LOCATION (Street a City or Town, State)	nd Number or F	Rural Floute Number,					
ETE	4 Homicide datermined											
1PLE	29a. CERTIFIER (Check only 0 CERTIFYING PHYSICIAN: To the best of my 0 C											
COMPLETED	2 MEOICAL EXAMINER: On the basis of axam	nination and/or investigation	on, in my opinion, death occ	ured at the time	e, data and place, and	due to the ca	suse(s) and manner as stated.					
BE CC	29b. SIGNATURE AND TITDE OF CERTIFIER	n	29c. LI	CENSE NUMBER	R 787	29d. DATE SH	GNED (Month, Day, Year)					
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	DE DEATH (ITEM 27) (3-)	Deleted 1	X	0806	13	26.95					
	CEBALLOS, M.D			PITAL	1 - TOI	NOLL	MD 21204					
	31. DAT MARK 3 0 1993 Sulla David	SIGNATURE SOME AND										

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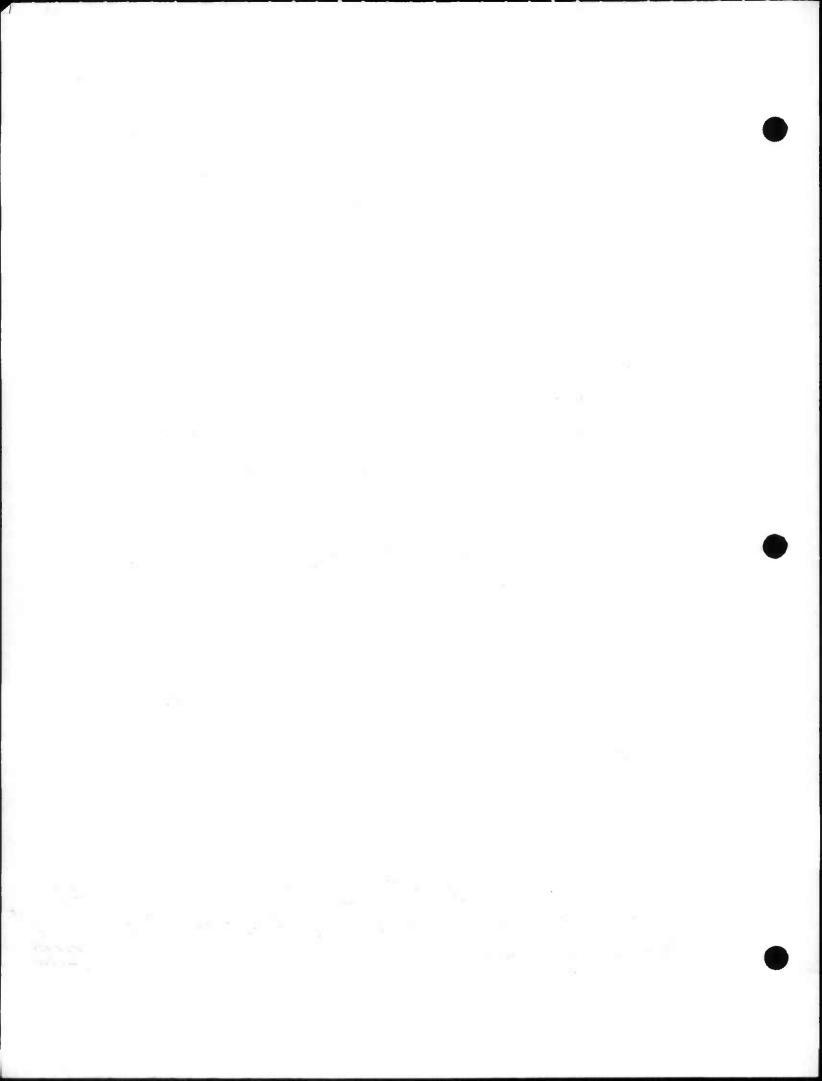
		1 - FOR STATE REGISTRAR	STATE OF MAR		D / DEPARTM			MENT	AL HYGIEN REG. NO				
		1. DECEDENT'S NAME (First, Middle, Lost)	aniel	Ma	urtin			MOI	E OF DEATH	7 0	YEAR	TIME OF DEATH PM	
2		4. SOCIAL SECURITY NUMBER 705-09-5273	1'∭ M 2 ☐ F	AGE (In vrs	YRS. MON	NDER 1 YEAR THS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DAT	E OF BIRTH rith, Day, Year)	B '	Country)	CE (State or Foreign	
, 2, 3 should	TOR	90. FACILITY NAME (If not institution, give street Baltonere Caure RESIDENCE OF DECEDENT	. ^	Ha			UST COCATION OF C			-	y of deat	H NOVE	
permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY			10c. CITY, TO	WN OR LOCAT					100	1. INSIDE CITY LIMITS?	
sit perm	FUNERAL	100. STREET AND NUMBER 1827 N. Monro	ne Steet				ZIP CODE	1 7		10g. CITIZE	N OF WHAT	COUNTRY?	
BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physician. The funeral director, page 5 should be detached for use as the burial-transit moval.		11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVI FORCES? 1 Y IF YES, GIVE WAR O	YES 2	₹NO	If yes, sp	ENDENT OF HISPA ecify Cuban, Mexic 2 NO Speci	NIC ORIC	ilN? (Specify Year o Rican, etc.)	s or No- 1	4. RACE — Black, W Specify:	American Indian,	
MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the burlat notified at once.	ED BY	3 Wildowed 4 Divorced 15. DECEDENT'S EDUC. (Specify only highest grade of	ATION	16a	. DECEDENT'S USUA	L OCCUPATION	ON .		Sb. KIND OF BU	SINESS/INDU		Blk.	
D 21; spital or ed for u	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)		(Give kind of work of life. Do NOT use retire Control	ed.)	st of working						
AN the hos detach	COMPL	17. FATHER'S NAME (First, Middle, Last)			50010	WIIOL	18. MOTHER'S N	AME (First	, Middle, Maiden	Sumeme)			
RYL ed by uld be	BE (Daniel Martir	1						Marti				
MAR retained 5 should notified	2	190. INFORMANT'S NAME (Type/Print) Frances Martir	1		196. MAILINO ADDI						4.0	7	
RE, nay be to set be st be		20a. METHOD OF DISPOSITION 1X Burial 2 Cremation 3 Remov	/L 75-		CE AND DATE OF DIS	POSITION (Na					MD. 21217 CATION — City of Town, State		
MO ge 6 r		4 Donation 5 Other (Specify)	20.2320.022		crematory or other plutus Me		ζ.	1	Ba	lto.	CO., N	1D	
BALTIMORE, er death. Page 6 may be the funeral director, page val.		21. SIGNATURE OF FUNERAL SERVICE LICE	L. Rus.	1			eph L. W. No		s Fun	eral	Home	21216	
hours or re or red		23. PART I. Enter the diseases, or co shock, or heart fellure. L IMMEDIATE CAUSE (Finel	emplications that cause o	used the	death. Do not en	nter tha mo	de of dying, su	ch as ca	rdiac or resp	iretory arrec	ot,	Approximate interval Between Onset and Death	
		disease or condition resulting in deeth)		CH	F								
K 68760, executed within and completely to burial, crematic event, t	-		OUE TO (OR A	AS A CON	ISEOUENCE OF):								
OX 68: Ox be execute sictan and confor to burial traumatic	IOITI	Sequentially list conditions, if any, leading to immediata	DUE TO (OR A		ISEQUENCE OF):		44.						
P.O. B h certificat anding phy Hygiene p	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR A	AS A CON	SEQUENCE OF):								
IDS, I the dear y the atte	AL C	PART II. Other significant conditions	contributing to deat	th but n	ot resulting in the	underiying	ceuse given in	Part I.	24s. WAS AN			RE AUTOPSY FINDINGS	
AL RECORDS, te law requires that the de has been signed by the al Dept. of Health and Ment n 23 shows any Injury	MEDIC		enal to	21/0	~e				PERFOR		OF OF	ILABLE PRIOR TO IPLETION OF CAUSE DEATH? YES 2 \(\sum \) NO	
F VITA SICIAN: The certificate ha the State Di the State Di	PHYSICIAN:		HOSPITAL:	Outpetler		IER:	ACE OF DEATH (C						
OF V PHYSICIA this certif with the	ЬΗΥ	27. MANNER OF DEATH	28a. DATE OF INJUI (Month, Day, Yea	RY	28b. TIME OF	28c. INJ	JRY AT RK?	_	SCRIBE HOW I	NJURY OCCU	RED		
ON OF DING PHYS After this of death with	ВУ	1 Natural 5 Pending 2 Accident Investigation				1 0	ES 2 NO						
DIVISION OF VITAL OR ATTENDING PHYSICIAN: The law O'NECTOR: After this certificate has hours after death with the State Dep Item 28 is marked, or item 23	ETED	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (\$	URY — At Specify)	t home, farm, street,	factory, office	•	261. LC	CATION (Street a y or Town, State)	and Number or	Rural Route	Number,	
로 가는 점	COMPL	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI 2 MEDICAL EXAMINER:	AN: To the bast of my kr	nowledge	death occurred at the death occurred at the death occurred at the death of the death occurred at the death occ	ne time, date	end place, and due	to the c	nuse(s) and mar ta and place, an	nner as stated	ceuse(a) and	I manner sa stated.	
D.7HE FUNER D.7HE FUNER De filed within	BE (29b. SIGNATURE AND TITLE OF CERTIFIER	~ >				29c. LICENSE NU			29d. DATE S	6 /	nth, Day, Year)	
MARKE E	0	30. NAME AND ADDRESS OF PERSON WHO					D375	22	٨	10	127		
196		MAR 3 0 1993	REGISTRARIS S			arle	Height	3	Ave.	Vsal	4' N	80515 CI	
		mwy 2 () 1993 Am	a Devident B	-plate	b .							- 1	

According to the second
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	CATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TOTHE RINGRAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
 M	D.T. P. C.	TO THE FUNER De filed within 7	IMPORTANT

TO BE COMPLETED BY FUNERAL DIRECTOR

							9:	3 0	8515
FOR STATE REGISTRAR	STATE OF MAR	YLAND / DEPART	CATE C	F HEALTH AND OF DEATH	MENTA	L HYGIEN			
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	E OF DEATH		YEAR 3.	TIME OF DEATH
		cE1veen			3	24	199		M.
213-62-4680	1 🗆 M 2 💢 F	GE (In yrs. last birthday) 39 YRS.	IF UNDER 1 YE. MONTHS DA	a diversi se inte	7. DATE (Mon	th, Day, Year)	954	Country)	CE (State or Foreign
9a. FACILITY NAME (If not inatitution, give stre	2 4 10332			WN OR LOCATION OF E	DEATN		9c. COUNT	Y OF DEATI	N
3832 Rolandview	Avenue		Balt	imore					
10a. STATE 10b. COUNTY			town on Lo			.			1. INSIDE CITY LIMITS? YES 2 NO
10m. STREET AND NUMBER 3832 Rolandview Av	/enue			101. ZIP CODE 21215				EN OF WHAT	COUNTRY?
11. MARITAL STATUS	12. WAS DECEDENT EVI	ER IN U.S. ARMED	13. WAS	DECENDENT OF HISPA	ANIC ORIGI	N? (Specify Yes	or No — 1		American Indian.
1)XX Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 Y	PR DATES	If yes	yes 2 NO Spec	can, Puarto	Ricen, etc.)		Black, WI Specify:	Black
15. DECEOENT'S EDUCA (Specify only highest grade of	TION ompleted)	16a. DECEDENT'S U	ork done during	PATION most of working	168	b. KIND OF BU	SINESS/INDU	STRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use	retired.)	16					
17. FATHER'S NAME (First, Middle, Last)		1.1	-	16. MOTHER'S W			Sumame)		
<u>Felton McElveen</u>				Jessie		Ruth			
19a. INFORMANT'S NAME (Type/Print) Jessie L. Ruth				eet and Number or Aural					
20a. METHOO OF DISPOSITION 1 Durial 2 Cremation 3 Remov	al from State	20b. PLACE AND DATE OF cemetery, crematory or oth	er plecel				CATION — CI		
4 Donation 5 Other (Specify)	NCEE	Baltimor	<u>e Ceme</u>			193 Ba	ltimor	re, Mo	
+ Gladus	Wans	\supset	Ma	e and adoress of F arch F/H w 300 Wabas	Vest	enue			
23. PART i. Enter the diseases, or co	mpilications that cau	ised the death. Do no	ot entar tha	moda of dying, su	ch as can	diec or reepi	ratory arres	st,	Approximata
shock, or haart failura. Li IMMEDIATE CAUSE (Finel	st only one ceuse o	n aach line.							intarval Between Onset and Death
disease or condition resulting in death)	- Q	rvical (and	91-					
	DUE TO (OR /	AS A CONSEQUENCE OF)							
Sequentially list conditions, b.	QUE TO (OR A	AS A CONSEQUENCE OF)	*						
If any, leeding to immediate cause. Entar UNDERLYING	,		•					j	
CAUSE (Disease or injury that initiated events	OUE TO (OR /	AS A CONSEQUENCE OF)	:						
resulting in death) LAST									
PART II. Other significant conditione	contributing to deat	h but not resulting in	the underi	Ving cause given in	n Part i.	24s. WAS AN	ALITOPSY	24h WEI	RE AUTOPSY FINDINGS
				,		PERFOR		AWA	ILABLE PRIOR TO
					_	I LI TES 2	Nº0		OEATH?
								, ,	,
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			. PLACE OF DEATH (C	heck only o	ne)			
1 VES 2 NO	☐ Inpatient 2 ☐ ER/0	Outpatient 3 DOA		Nome 5 - Residence	8 🗆 Othe	er (Specify)			
27. MANNER OF DEATH	28a. DATE OF INJU (Month, Day, Yes		RY	INJURY AT WORK?	28d. DE	SCRIBE NOW I	JURY OCCU	RED	
Accident Investigation	28 PLACE OF IN I	URY — At home, farm, str		YES 2 NO					
3 Suicide 8 Could not be 4 Homicide detarmined	building, etc. (Specify)	reet, rectory, t	nnes	City	CATION (Street a or Town, Stete)	nd Number or	Hurai Houte	Number,
29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICI. 2 MEDICAL EXAMINER:									i manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIES	sul !	m de	70	29c. LICENSE NU		7-7		BIGNED (Mor	
30. NAME AND ADDRESS OF PERSON WILD	COMPLETED CAUSE OF	DEATN (ITEM 27) (Type, F	md !	Hospill	Den:	toBle	22	Sou	the treme
31. DAYE FILED (MONTH, Day, Year) MAR 3 () 1993	PREGISTRAR'S S	IGNATURE		-110101	1	/0	[N]	zajj	2/20/

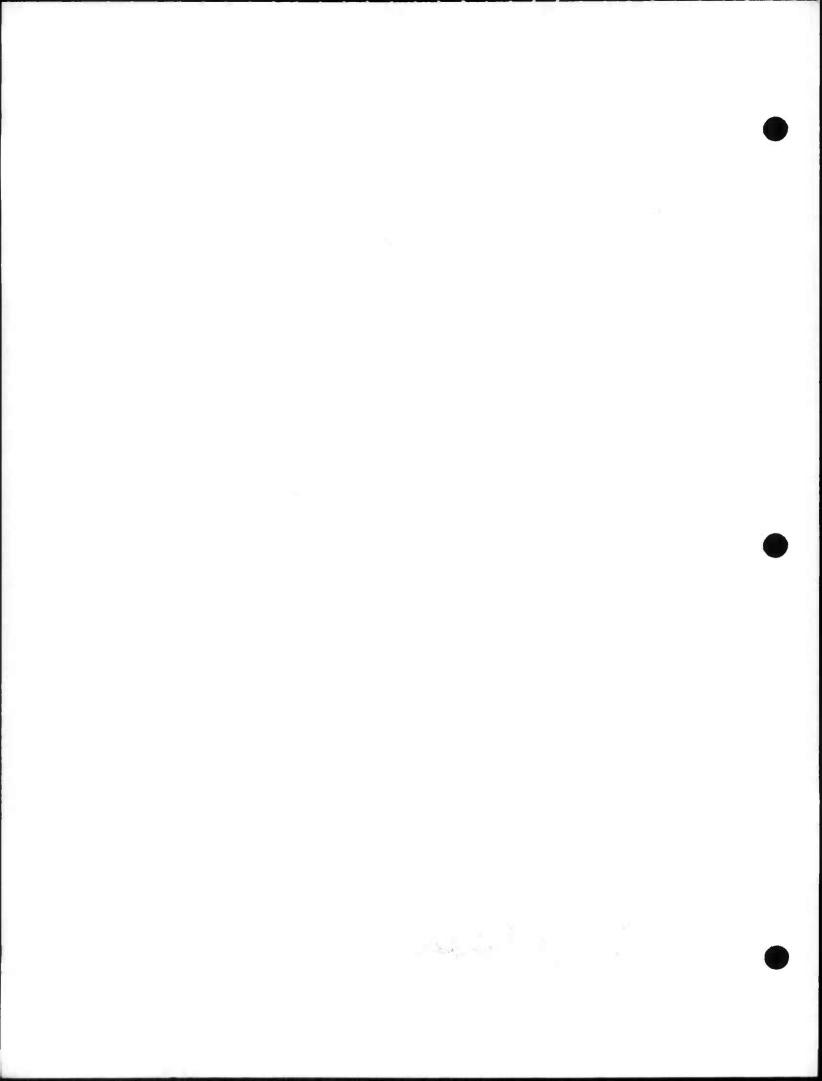


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	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DE CER	PARTMENT O	F HEALTH AND OF DEATH	MENTAL HYGI REG.						
-	1. DECEDENT'S NAME (First, Middle, Last)	MINEEY				2. DATE OF DEATH		3. TIME OF DEATH S45 P				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birtholay) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Morth, Day, Year) 12 M 2 F 80 YRS. MONTHS DAYS HOURS MHI. 1/1-1/2 M2											
TOR	96. FACILITY NAME (II not authorized give street and number) # Groot Hospital Center Baltimore 96. COUNTY OF DEATH =======											
DIRECTOR	10a. STATE 10b. COUNT	Y	10	Baltimo				10d. INSIDE CITY LIMITS? 1 X YES 2 NO				
ERAL	100. STREET AND NUMBER 619 Annabel Ave	enue			10f. ZIP CDDE 21225		1 *	N OF WHAT COUNTRY?				
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 VE IF YES, GIVE WAR OR	S 2 NO	If yo	DECENDENT OF HISP/ s, specify Cuban, Maxk YES 2 X NO Speci	can, Puerto Rican, etc.	Yes or No — 14	I. RACE — American Indian, Black, White, etc. Specify: White				
PLETED	15. DECEDENT'S EDU (Specilly only highest gradi Elementary/Secondary (0-12) 12th Grade	CATION o completed) College (1-4 or 5+)	(Give k	ENT'S USUAL OCCU ind of work done durin NOT use retired.) rolman	PATION g most of working		BUSINESS/INDUS	STRY				
E COMPL	17. FATHER'S NAME (First, Middle, Last)	Jacob Mink	evicus			AME (First, Middle, Mei phie Sab						
TO B												
	20a. METHOD OF DISPOSITION 1 № Burlel 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)		e, Maryland									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225											
	23. PART I. Enter the diseases, pr complicatione that caused the deeth. Do not enter the mode of dying, such as cardiec or reepiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (DR AS A CONSEQUENCE DF):											
MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): A Arrhy A hn vass d. Africal Arrhy A hn vass											
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DE											
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	6. PLACE DF DEATH (C	theck only one)						
PH	1 VES 2 NO 27. MANNER OF DEATH 1. Netural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year,	Y 28	b. TIME OF 180	Home 5 Residence INJURY AT WORK? YES 2 ND	6 Other (Specify) 28d. DESCRIBE HO	W INJURY OCCU	RED				
тер ву	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJUI building, etc. (Sc	RY — Al home, pecify)			28t. LOCATION (Str. City or Town, S.		Rural Route Number,				
COMPLE		ICIAN: To the best of my kno						euse(e) end menner ee stated,				

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after seath Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely fined in by the times director, page 5 should be detached for use as the burial-transit narmit Panes 1.2.3 should	ental Hygiene prior to burial, cremation, or removal.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exe	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician an	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumal

	REGISTRAN			LNIII	CALE	<u>U</u>	DEATH		RI	EG. NO.				
	DECEDENT'S NAME (First, Middle, MARIA	Last) S		N					2. DATE OF DEATH DAY O3 24 93 05:45 PM					
	4. SOCIAL SECURITY NUMBER 212. 70 402	5. SEX 3 1 □ M 2 🂢 F	6. AGE (In yrs. lat		IF UNDER 1		IF UNDER 24	_	. DATE OF B	PTH (Year)		8. BIRTH Country	PLACE (State or Foreign	
	9a. FACILITY NAME (If not institution,		00	Tha.	9b. CITY. T	OWN O	R LOCATION	OF DEAT	01/17	/190		Tur	-	
DIRECTOR	NORTH ARUNDEL HOSPITAL ASSOCIATI						BURNII						COUNTY	
E	10e. STATE 10b. CO	UNTY		10c. CIT	Y, TOWN OR	LOCATI	ION						10d. INSIDE CITY	
	4	Anne Arunde	el	Pa	saden	a					_		LIMITS? 1 YES 2 NO	
FUNERAL	100. STREET AND NUMBER 7709 Lee Driv					10f.	ZIP CODE	2				10g. CITIZEN OF WHAT COUNTRY?		
ᄬ	11. MARITAL STATUS		INT EVER IN U.S. AF	RMED	12 WA	S DECE	2112		ORIGIN? (Sp			aly		
BY FI	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES?	1 YES 2 X	NO	If y	es, spe	cify Cuben, N	Wexicen, I Specify:	Puerto Rican,	etc.)	or No—	Black Specif	- American Indian, White, etc. White	
	15. DECEDENT'S (Specify only highest	EDUCATION grade completed)	16a. OE	CEDENT'S	USUAL OCC	JPATIO	N		16b. KINE	OF BUS	INESS/IND	DUSTRY	WIII CE	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or S	1+)	Do NOT US	vork done dur e retired.)	ing mos	t or wonang		Ho	ma 1	lake:			
ŏ.	17. FATHER'S NAME (First, Middle, Las	1)	111	Ouben	1110		18. MOTHER	'S NAME	(First, Middle			-		
BEC		Richard :	Isolabel	la					oina T		,	los		
2	190. INFORMANT'S NAME (Type/Print) Antonio Mast:	rojenj	19	b. MAILING	ADDRESS (S	treet an			te Number, Cl					
	200. METHOD OF DISPOSITION	oreni			Lee Di			rasa	dena,	_	_			
	1 X Buriel 2 Cremetion 3 C				her place)			OATE 20c. LOCATION — City or Town, State						
- 1	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	7 02011	Haven Memorial Park 3/27 Glen Burnie, Mary 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A.										
	1/george	1/1º	nee		400	orge 01 I	e J. G Ritchi	ionce Le Hi	e Fune wv. I	eral Balt	HOM imor	e P. <i>I</i> e. Mo	A. A. 21225	
	23. PART I. Enter the diseased shock, or heart fall IMMEDIATE CAUSE (Finel disease or condition resulting in death)	ure. List only ona ca	at caused the de luse on each line O (OR AS A CONSE	9.		**		, such s	e cerdiac d	or reapir	atory en	rest,	Approximate Interval Between Onset end Death	
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST	с	O (OR AS A CONSEC											
5	PART II. Other significent cond	Itlons contributing to	death but not r	eeulting i	n the unde	rivina	cause give	en In Pa	rt I 24a	WAS AN	urmey	245	WERE AUTOPSY FINDINGS	
EDICAL	Dules					,	outse give	J11 111 1 Q		PERFORI	WED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
									_ '	TES 2	DENO		OF DEATH?	
Ä	25. WAS CASE REFERRED TO MEDIC													
HYSICIAN: M	EXAMINER?	HOSPITAL:	☐ ER/Outpatient 3		OTHER:		ACE OF DEAT							
	27. MANNER OF DEATH	28e. DATE O	F INJURY	26b. TIME	OF 28	c. INJU	IRY AT		Other (Spe		JURY OC	CURED		
BY P	1 Natural 5 Pending 2 Accident Investigat		Day, Year)	INJ		NOR I [] YE	IK? ES 2 N							
	3 Suicide 6 Could no 4 Homicide determine	Duliding	OF INJURY — At ho , etc. (Specify)	me, farm, s	treet, fectory	office		28	of LOCATION City or Tow	(Street ar rn, State)	nd Number	or Rural Ro	oute Number,	
COMPLETED		HYSICIAN: To the best of												
	29b. SIGNATURE AND TITLE OF CER	MINER: On the basis of o		investigation	i, in my opin					place, end				
	And A conce	m					036		5		DATE	3 / L	Month, Day, Year)	
	MARK A. GOLDS					Y,S	W. #60	01/G	LEN B	URNI	E, M	ARYL	AND 21061	
	31. MAR 3 0 1993	Jula David	ARIS SMATURE	Ē.										



PHYSICIAN:

BY

COMPLETED

BE

1 Natural

2 Accident

3 Suicide

4 Homicide

93 08518 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MON 3 YEAR Mitchell dward 93 AM 5 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HIRS 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign Country) A A Country) 219 32-88 th, Day, Year) 1 M 2 - F HOURS DAYS YRS. 9.11. NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Bron Fitchie Hospice DIRECTOR Baltimore RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel 1 YES 2 NO GlenBurnie FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? P.O. BOX 1356 21060 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, stc. tf yes, spectfy Cuban, Mexican, Pu 1 ☐ YES 2 ☐ NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced White Korean COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a, DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 8th Tow Motor Operator General 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) Cyrus W. Mitchell Minnie E. Shipley BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 P.O. Box 1356 GLenBurnie, Joe Ann Mitchell Maryland 21060 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State 1 Buriet 2 Commation 8 Re 4 Donation 5 Other (Specify) cemetery, crematory or other piece Green Mount Cemetery 3/26 Baltimore, Maryland 21. SIGNATURE OF PINE 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Homes 5695 Main St. Elkridge, Maryland 23. PART I. Enter the diseases or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart tenture. List only one ceuse on each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition lung concer & brain netus fases Dinary resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO JOB AS A CONSEQUENCE OF that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

Diables

1 - YES 2 NO

1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) OTHER: 1 - YES 2 NO 1 - Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Realdence 6 Other (Specify) 27. MANNER OF DEATH

26a. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify)

26a. DATE OF INJURY (Month, Day, Year)

26b. TIME OF 28c. INJURY AT WORK? 1 YES 2 NO 6 Other (Specify) Hozur

28d. DESCRIBE HOW INJURY OCCURED

261. LOCATION (Street and Number or Rural Route Number, City or Town, State)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and menner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner ea stated.

296. SIGNATURE AND TITLE OF CERTIFIER minerelle - w

5 Pending

6 Could not be

29c. LICENSE NUMBER

29d. DATE SIGNEO (Month, Day, Year) ▶ 3.25.93

20. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (15700, PHIN) INTO AN AN EXCELLIBITION OF THE CONTROL O

31. MAR 3 0 1993

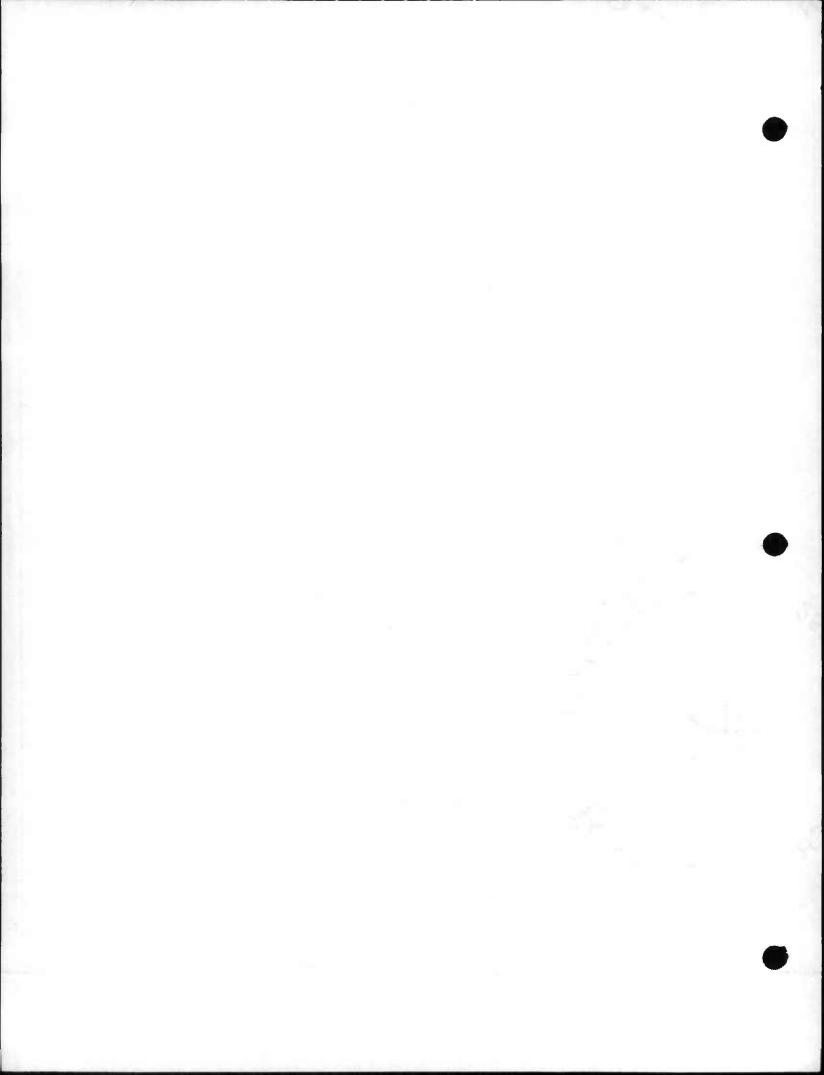
Sult 302

Glen Burnic ing. 2106 and the control of the control of Contract Con

manufactured Table 198 of SAM

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

		REGISTHAR		CERTIFIC	AIE	T DEALH	REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)	Freda M. Mi	A E C			2. DATE OF DEATH	8 9	3. TIME OF DEATH A
-		4. SOCIAL SECURITY NUMBER 215-03-8419	5. SEX 6. AGE	2	F UNDER 1 YEA		7. DATE OF BIRTH (Month, Day, Year)	-04	RTNPLACE (State or Foreign untry)
2, 3 should	стов	9a. FACILITY NAME (If not institution, give s	HOSPITC	al e	b. CITY, TOY	WHO RELOCATION OF DI	EATN	9c. COUNTY O	BOULT SOLUTION
Pages 1,	EC	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	Y	10c. CITY, 1	TOWN OR LO	OCATION			10d. INSIDE CITY
permit. Pag	L DIRE	Maryland Balt	imore County	7 Ba	ltimo			Trans.	1 YES 2 NO
동	FUNERAL	1706 Oakleigh Cou				101. ZIP CODE 21234		U.S.A	F WHAT COUNTRY?
0020 one physician. The burlat-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Midowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 XNO	If yes	DECENDENT OF NISPAI , specify Cuban, Mexica YES 2 X NO Specif		B	ACE — American Indian, lack, White, etc. pecify: 11te
200	ETED	15. DECEDENT'S EDU (Specify only highest grade		16a, DECEDENT'S US (Give kind of work	k done during		16b. KIND OF BUS		
8	COMPLET	Elementary/Secondary (0-12) 8th Grade	College (1-4 or 5+)	Sales	etired.)		May Con	manu	
YLAN by the hor be detach at once.		17. FATNER'S NAME (First, Middle, Last)		Dares		18. MOTNER'S NA	ME (First, Middle, Meiden		
3YL d by d d be	BE C	George Morgereth				Elizak	æth		
MARYLAN retained by the hoi 5 should be detach notified at once.	10	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Town		
E, P		Evelyn E. Yeager	200	11/06 Oa.			Baltimore,	MaryLar CATION — City of	
TIMORE 1. Page 6 may ral director, pa		1 Burlef 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State cen	petery, crematory or other reen Moun	place) t. Cem	eterv			, Maryland
ALTIMO death, Page s funeral direc I.		21. SIGNATURE OF FUNERAL SERVICE LIC		,	22. NAM	E AND ADDRESS OF FA	CILITY	- Camillo I Co	, idiy tara
		▶ Kallite	~ m.m.	rysky	6415	Belair Ro	ad, Baltin	more, Ma	aryland 21206
urs af In by r remo		23. PART i. Enter the diseases, or shock, or heart failure.	complications that cause List only one cause on e	d the death to not each line.	enter tha	mode of dying, suc	h as cardiac or reapi	iratory arrest,	Approximate interval Between
24 fille tion,		iMMEDIATE CAUSE (Final disease or condition	ische	Mia		MANIA	1112 OA	THU	Onset and Death
ted within 24 completely fills ial, cremation, event, the	1	resulting in death)		CONSEQUENCE OF):		AIULUI	MYOPA	111/	
executed within and completely o burial, creman natic event,	NC	Sequentially list conditions,	· MITRA	(IAL	VE K	EGUNG	SITAT	TION
or to	ATI	if any, leading to immediate cause. Enter UNDERLYING	COM	CONSEQUENCE OF):	1_	LCANT	- R/	CK	
. 2 2 2	LIFE	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):			A = =	1:11	0
O # # # 9	CERTIFICATION	resulting in death) LAST	a CONG	ESTIVE	5	IteA.	el ti	AILU	RE
S 5		PART ii. Other algnificant condition	s contributing to death b	out not resulting in	the underl	ying cause given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
CORD res that the signed by the tealth and N	EDICAL						1 _ YES 2		COMPLETION OF CAUSE OF DEATH?
REGUI Peen S of H	Σ	-						1	1 TYES 2 NO
VITAL RI CIAN: The law req rutificate has been he State Dept. of or Item 23 sh	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			26	S. PLACE OF DEATH (Ch	eck only one)		
OF VITAL HYSICIAN: The law his certificate has with the State Dep ked, or Item 23	YSIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp		THER:	Home 5 🗆 Residence	8 Other (Specify)	_	
HYSIG this of with t		27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME C	Y	INJURY AT WORK?	28d. DEŞCRIBE NOW II	NJURY OCCURED	
NOING F. After death	Э ВУ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY	— At home, farm, atre		YES 2 NO	281, LOCATION (Street o	and Number or Rui	ral Route Number,
DIVISION OR ATTENDING F DIRECTOR: After I hours after death Item 28 is mar	ETED	4 Homicide determined	building, etc. (Spec	city)			City or Town, State)	III- 2020 I -6-	
DIV AL OR A AL DIREC 2 hours If Item	COMPLET		CIAN: To the bast of my know						
HOSPIT UNER Vithin 7	S S	2 MEDICAL EXAMINE	R: On the basis of examination	n and/or investigation,	in my opinio	n, death occured at the	time, date and place, an	d due to the ceu	se(e) end manner ee stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 i	BE	296. SIGNATURE AND TITLE OF CERTIFIES	200			29c. LICENSE NUI	ABER O	29d. DATE SIGN	NED (Month, Day, Year)
6633	2	30. NAME AND ADDRESS OF PERSON WIN	COMPLETED CAUSE OF DE	ATN (ITEM 27) (Type, Pr	int)	I D a	0000	, 2.	48.73.
		CEBALLOS,	MD 5	J. JOJE	8H	HOSPH	AC -7	owso.	N,MD-2120
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE					,



FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERT	FIFIC	ATE OF	DEATH	REG. N	Ю.					
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH			3. TIME OF DEATH			
- 9	EFFIE MAE MEISE				MONTH	DAY	YEAR	1.111			
- 8				_	MARCH	22 19	193	1493 "			
	1/ 3. 451 0411	100	THE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH Count	IPLACE (State or Foreign			
	220-18-4206 1 M 2 A F 8/ YI	RS.	UAI O	HOURS MIN.	09-16-1			ryland			
	9a. FACILITY NAME (If not Institution, give street and number)	9b.	CITY, TOWN	OR LOCATION OF DE		A CONTRACTOR OF THE PARTY OF TH	INTY OF D				
Œ	7819 TICK NECK RD.		D.			111					
2	1819 TICK NECK KD. PASADENA ANNE ARU										
DIRECTOR		CITY TO	WN OR LOC	ATION			_	Car mans arm			
<u>m</u>								10d. INSIDE CITY LIMITS?			
	Maryland Anne Arundel	Pas	aden	<u>a</u>				XX YES 2 NO			
₹	10e. STREET AND NUMBER		- 1	Of. ZIP CODE		10g. CIT	IZEN OF V	WHAT COUNTRY?			
6	7819 Tick Neck Road		- 1	21122		IIn	1+00	States			
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED		13. WAS DE	CENDENT OF HISPAN	IC ORIGIN2 (Specify						
	1 Never Merried 2 Merried FORCES? 1 YES 2 X NO		If yes, s	pecify Cuban, Mexica	n, Puarto Rican, etc.)	100 01 110-	Biaci	E — American Indian, k, Whita, etc.			
BY	3√XWidowed 4 □ Divorced IF YES, GIVE WAR OR DATES		1 L YE	S 2 XNO Specify	:		Speci				
	15. DECEDENT'S EDUCATION 16a. DECEDE				1			Mite			
쁘ㅣ	(Specify only highest grade completed) (Give kin	d of work	done during m	ION lost of working	16b, KIND OF E	SUSINESS/IN	DUSTRY				
ا ر	Elementary/Secondary (0-12) College (1-4 or 5+)	OT use ret	ired.)								
7	8th Grade Home	emak	er		Dom	esti	C				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAI	ME (First, Middle, Meld	en Sumame)					
	Robert E. Lee	f		Clara	Lillie	Jones	S				
BE		I INC ADD	DE00 (0	and Number or Rural F							
임	100, 110							1001			
		4 A.	rbor	Drive;G1	en Burn	ie,M	d • 2	21061			
	20a. METHOD OF DISPOSITION TO Burlal 2 Cremation 3 Removal from Stata 20b. PLACE AND D cemetery, crematon			(ame of	OATE 20c.	LOCATION -	City or To	wn, Stata			
		or other p	Mem	. Park 3	3+25-93	Glen	Rur	nie, Md.			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME /	ND ADDRESS OF FAC				eral Home			
	Dames of Achielem So		220	1 36							
	James F. Hackman Jr.							a,Md.21122			
	23. PART I. Enter the diseases, or complications that caused the death.	Do not a	ntar tha m	oda of dying, suct	aa cardiac or res	piratory ar	reat,	Approximata			
	ahock, or heart failure. List only one cause on each line. iMMEDIATE CAUSE (Final							Interval Between			
	disease or condition	1 2	1 ' .	T	1	4		Onset and Death			
	disease or condition resulting in death) a. Juste Due To (or AS A CONSEQUENCE)	Hra	MAC	LNSU	4-1010	VC'	Y				
	DUE TO (OR AS A CONSEQUENC	CE OF):									
Z	Sequentially list conditions, b. 15000	/						1			
CERTIFICATION	if any, isading to immediate	CE OF):									
5	CAUSE (Disease or injury										
<u> </u>	that initiated events OUE TO (OR AS A CONSEQUENCE	CE OF):									
=	resulting in death) LAST										
5											
┪║	PART II. Other significant conditions contributing to death but not result	ing in th	e underiyir	ng cause givan in l		N AUTOPSY	24b.	WERE AUTOPSY FINDINGS			
DICAL						ORMED?	- 1	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
					1 _ YES	2 XNO		OF DEATH?			
M								1 YES 2 NO			
Ž											
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	1 =		LACE OF OEATH (Che	ck only one)						
n	1 YES 2 NO 1 Inpetiant 2 ER/Outpetient 3 DO		HER: Nursing Hor	ne 5 N Bealdence	5 Other (Specify)						
Ē	27. MANNER OF OEATH 28a. DATE OF INJURY 26b.	TIME OF	28c. IN	JURY AT	28d. DESCRIBE HOW	INJURY OC	CURED				
- 1	1 Netural 5 Pending (Month, Day, Year)	INJURY	M 1 🗆	ORK? YES 2 NO				- 1			
0	2 Accident Investigation 3 Suicide 6 Could not be 28a. PLACE OF INJURY — At home, fa	en elecat									
3	3 Suicide 6 Could not be building, atc. (Specify)	rm, street	, ractory, orri		281. LOCATION (Stree City or Town, State		or Rural R	loute Number,			
COMPLE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the ilme, data and place, end due to the cause(a) and manner as stated.										
٤	one) 2 MEDICAL EXAMINER: On the baels of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) and manner as stated.										
ರ					me, oate and place,	en	ie causaje,	and mainer as scaled.			
崩	296. SIGNATURE AND TITLE OF CERTIFICATION	00	when	29c. LICENSE NUM	BER	29d. DAT	E SIGNEO	(Month, Del, Year)			
2	Mulling The Ding	The same	1	11000	054	1 2	5/2	4/93			
- [30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)	Type, Print)	0:0		1 4	/				
	MIIIIAM P. DINES,	n [)	NOB	0099		20	7/1			
	31. DAT BILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	- ~-			/- /		10	/			
	MAR 3 0 1993 Silve Deviden Mandelle							1			

permitted 1, 2, 3 should

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

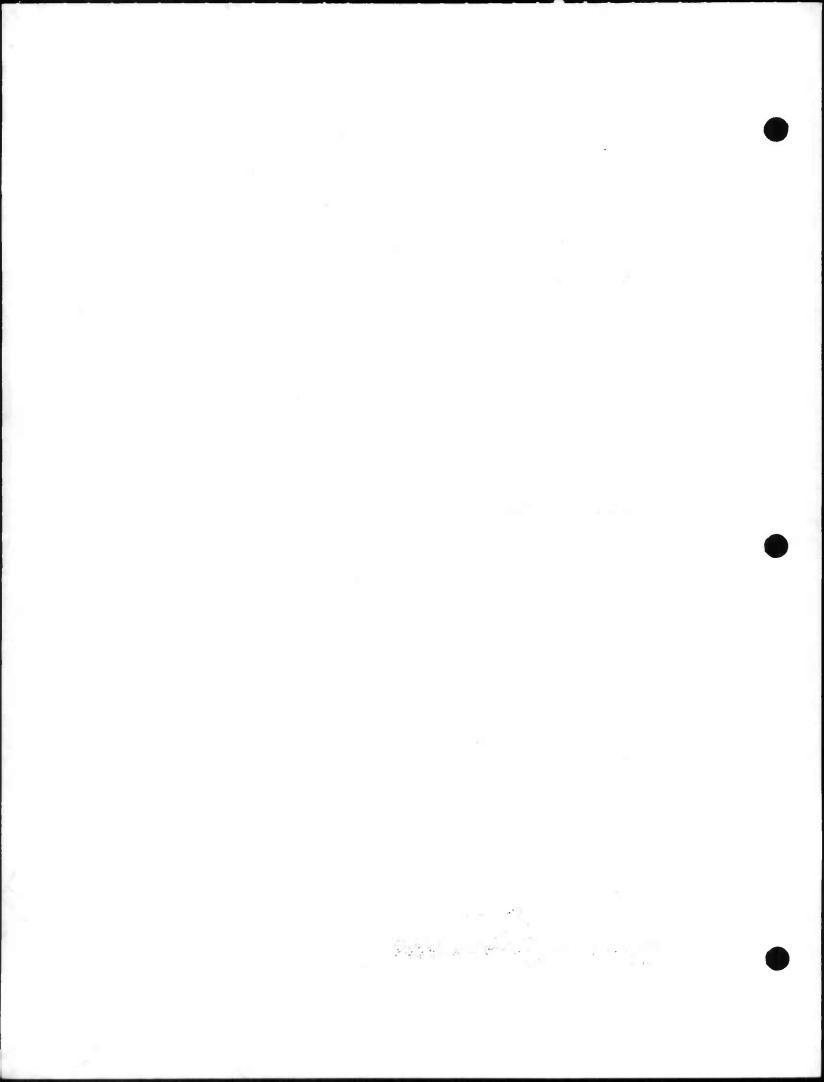
BALTIMORE, MARYLAND 21215-0020	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or executed within 24 hours after death.	DIRECTION After this cartificate has been closed by the attending physician and completely filled in he the forced discovery access to absolute the description of the first o
	thin 24 hours aft	staly filled in he
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	v requires that the death certificate be executed with	been signed by the attending physician and complet
DIVISION OF VITAL	OR ATTENDING PHYSICIAN: The law	DIRECTOR: After this certificate has by

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

physician.

	1 - FOR STATE REGISTRAR	STATE OF MARY		TMENT OF H			HYGIENE REG. NO.				
1	1. DECEDENT'S NAME (First, Middle, Lest) Marion	R.		McLe11a		2. DATE OF MONTH March		19	YEAR 93	3. TIME OF OEATH 1:10 A.Mu	
	4. SOCIAL SECURITY NUMBER 213 14 3322	1 💢 M 2 🗆 F	(In yrs. lest birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, Do July	ey, Year)		Country	PLACE (State or Foreign ryland	
TOR	90. FACILITY NAME (If not institution, give so 900 Waterview Dr. RESIDENCE OF DECEDENT	treet end number)			Baltimore				9c. COUNTY OF DEATH Anne Arundel		
DIRECTOR	10e. STATE 10b. COUNTY	Arundel	10c. CIT	Y, TOWN OR LOCAT	Baltimo	ore			10d. INSIDE CITY LIMITS?		
FUNERAL	100. STREET AND NUMBER 900 Waterview Dr			101	ZIP CODE	26				1 ☐ YES 2 ☑ NO HAT COUNTRY? States	
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEOENT EVER FORCES? 1 TY YES IF YES, GIVE WAR OR O World War	2 NO	RMEO 13. WAS DECENDENT OF H			Specify Yee o n, etc.)		4. RACE — American Indian, Black, White, etc. Specify: White		
COMPLETED	15. OECEOENT'S EOUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give kind of v	USUAL OCCUPATION Work done during more retired.)	st of working	Po	olice	Depa	rtm	ent	
BE CON	17. FATHER'S NAME (First, Middle, Last) Marion	R.	McLella	an	18. MOTHER'S NA Emma			_		rtimer	
2	Pat Stephens			Accoress (Street e				State, Zip Co 2112	_		
20s. METHOD OF OISPOSITION 1 CyBurlet 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20s. PLACE ANO OATE OF OISPOSITION (Name of cametery, crematory or other place) Clen Haven Memorial Park 4/1/93 Clen Burn 22s. NAME AND ADDRESS OF FACILITY MCCully Funeral Home of Pasade									urn	ie, MD	
CERTIFICATION										Interval Between Onset and Death 39 RS	
Ä	PART II. Other significent conditions	s contributing to deeth b	out not resulting i	not resulting in the underlying ceuse given in			n Part I. 24a. WAS AN AUTOPSY PERFORMEO? 1 YES 2 NO			WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF CEATH? 1 YES 2 NO	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Out	netled 3 700A	28, PL OTHER: 4 □ Nursing Home	ACE OF OEATH (Ch						
ВУ РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	E OF 28c. INJU	JRY AT	28d. OESCRII		URY OCCUP	REO		
	3 Suicide 8 Could not be datermined	28e. PLACE OF INJURY building, atc. (Spe	f — At home, ferm, s cify)	treet, lectory, office		281. LOCATIO City or To	LOCATION (Street end Number or Rural Route Number, City or Town, State)				
COMPLETED		CIAN: To the beat of my know R: On the beats of examination							euse(e)	end menner es stated.	
O BE C	296. SIGNATURE AND TITLE OF CERTIFIER		5					Ped. DATE S	ad. DATE SIGNEO (Month., Day, Year)		
-	30 MAME AND ADDRESS OF PERSON WHO	12172 100	3001	D. HAN	IVERS	NEGE!	B	22 70	.10	1)21225	
	31. DATE MARY 3 0 1993	AT CHECKEN SIGN	Approved				7				



FOR STATE REGISTRAR

		ENTIFICATE O	DEATH	REG. NO								
	Swearinger	lary		2. DATE OF DEATH DATE OF DATE	AY GAR	3. TIME OF DEATH						
	4. SOCIAL SECURITY NUMBER 3. SEX 5. SEX 1 □ M 2 X F 6. AGE (In yrs. le	yrs. Wonths Days		7. DATE OF BIRTH (Month, Day, Year) 7/3/1915	8. BIRTH	PLACE (State or Foreign						
R	9a. FACILITY NAME (If not institution, give etreet end number)	9b. CITY, TOW	N OR LOCATION OF DE		9c. COUNTY OF D							
BY FUNERAL DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY	10c. CITY, TOWN OR LOC	ATION		Balto	10d. INSIDE CITY						
	Maryland NA 100. STREET AND NUMBER	Baltimore		rooklyn)		LIMITS?						
	3705 Eighth Street,		101. ZIP CODE 21225		10g. CITIZEN OF V	NNAT COUNTRY?						
	11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EYER IN U.S. AF FORCES? 1 YES 2 WILDOWS IF YES, GIVE WAR OR DATES	NO If yea,	ECENDENT OF NISPAN specify Cuben, Mexical ES 2 X NO Specify			American Indien, k, White, etc.						
Exeb	(Specify only highest grade completed) (G	CEDENT'S USUAL OCCUPA ive kind of work done during i Do NOT use retired.)	TION most of working	16b. KIND OF BUS	SINESS/INDUSTRY							
TO BE COMPLE	12th Grade	Homemaker		Hous	ewife							
	17. Father's NAME (First, Middle, Last) Berkley Clifton Robertson		18. MOTNER'S NAI	Smith Ro								
5	Rev. James D. Pope	3801 Fifth	St., Bal	timore, Ma	n, State, Zip Code) ryland	21225						
	1 X Buriel 2 Cremellon 3 Removal from State Cemetery Cre	and date of disposition (in matery or other place) and Veteran			CATION - City or To	_{wn, State} e, Maryland						
		22. NAME AND ADDRESS OF FACILITY MCCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 2122										
MEDICAL CERTIFICATION	23. PART I. Enter the diseases, or complications that ceused the disease brock, or heart feliure. List only one ceuse on each line IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if erry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	MERS DUENCE OF):				Approximate interval Batween Onset and Dsath						
	PART II. Other eignificent conditions contributing to death but not re DIAISETES MELLITURE	AUTOPSY 24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OTHER:	PLACE OF DEATH (Che	ck only one)								
	1 VES 2 NO 1 Inpatient 2 ER/Outpetient 3 27. MANNER OF DEATN 1 Netural 5 Pending 28a. DATE OF INJURY (Month, Dey, Year)	DOA 4/M Nursing Ho 26b. TIME OF 1NJURY 28c. IN	ORK?	Other (Specify) 28d. DESCRIBE NOW IN	JURY OCCURED							
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At how building, etc. (Specify)		YES 2 NO	281. LOCATION (Street a. City or Town, State)	nd Number or Rural R	oute Number,						
COMPLETE	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, daily one) 2 MEDICAL EXAMINER: On the basic of examination end/or in the examination	ath occurred at the time, dat	e end place, end due t	o the cause(a) and men	ner se stated. I due to the cause(e)	end manner ee stated.						
O BE C	296. SIGNATURE AND THILE ON CERTIFIER		29c LICENSE NUM	253	29d. DATE SIGNED	(Month, Day, Year)						
-	30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEN Dr. Dharmasena, M.D.	710 Chu	rch St.,	Baltimore	, Maryla	nd 21225						
	MAR 3 0 1993 Julia Davidson-Mondelle											
						DHMH-16 Rev 1/8						

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

08522

1	۱ -	FOR STATE REGISTR
	1. D	ECEDENT'S
	MA	ARIE
г		

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

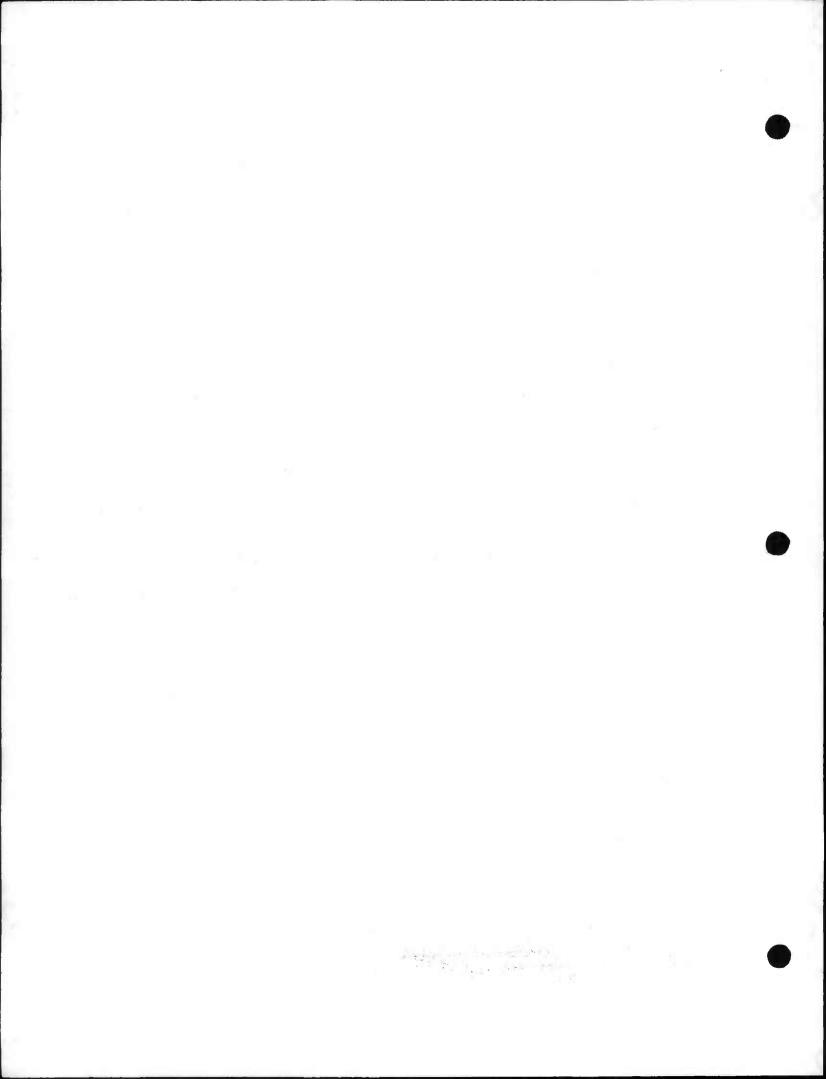
	REGISTRAR		CERTIFIC	ATE OF	DEATH	REG. NO						
18	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	1 Tel	3. TIME OF DEATH				
	MARIE M (MA	ARY)	MAXV	TITE		03 22		- 5.5 In 195.21				
8	4. SOCIAL SECURITY NUMBER 5. SEX			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	The second second	9:35 AM M				
- 1		M 2XXF 76		NTHE DAYS	HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) 9/19/191	Count	HPLACE (State or Foreign ry) aryland				
	Se. FACILITY NAME (If not institution, give street and	number)	.98	. CITY, TOWN	OR LOCATION OF DE		9c. COUNTY OF D					
TOR	NORTH ARUNDEL HOSPITA	AL ASSOCIAT	ION	GLEN I	BURNIE		A.A.	COUNTY				
E I	10e. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCA	TION			10d. INSIDE CITY				
E	Maryland Anne Art	unde1	G1	en Bur	nie,		LIMITS? 1 TYES 2 X NO					
FUNERAL DIRECTOR	911 Andrews Road,			10	1. ZIP CODE 210	60	WHAT COUNTRY?					
ξ	11. MARITAL STATUS 12. WA	S DECEDENT EVER IN U.S.	ARMED	13 WAS DE		IIC ORIGIN? (Specify Yea	USA	E — American Indian,				
BY FI	1 Never Married 2 V Married FO	RCES? 1 YES 2) YES, GIVE WAR OR DATES	Ç/(νο	If yes, sp	ecify Cuban, Mexica 2 X NO Specify	n, Puerto Rican, etc.)	Blec Spec	k, White, atc.				
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT user retired.) 16b. KIND OF BUSINESS/INDUSTRY											
COMPLETED	PERSONAL PROPERTY AND ADDRESS OF THE PERSON	ge (1-4 or 5+)	ille. Do NOT use re Conveyer			A1 Go	rdon and	Con.				
₹	17. FATHER'S NAME (First, Middle, Last)		Jonveyer	Deit				3011				
BE CC		itkins				ME (First, Middle, Melden Ce Estell		se Matkins				
TO B	190. INFORMANT'S NAME (Type/Print) Mr. Robert George M	laxwell	19b. MAILING AD 911 A	ndrews	and Number or Rural I	Route Number, City or Town	n, State, Zip Code)	and 21060				
	20a. METHOD OF DISPOSITION	20h Pt A	CE AND DATE OF D	N. MOITISON (N.	ama of	047E 200 100	CATION Character					
	4 Donatton 5 Other (Specify) Glen Haven Memorial Pk. 3/24/93 Glen Burnie, Maryland											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	/ Kevin E.	Ecker	MCCU	NO ADDRESS OF FA	ral Home o	f Brookl	vn				
	· x / / C			237	E. Patap	sco Ave.,	Balto., Ì					
	23. PART I. Enter the diseases, or complic ahock, or heart failure. List on	ations thet caused the ly one ceuse on each i	deeth. Do not line.	enter the mo	de of dying, suci	h aa cardiec or reapl	ratory arrest,	Approximete interval Between				
	iMMEDIATE CAUSE (Finel disease or condition	Par Sign	10		ahie	- h		Onset and Death				
	resulting in death) a. Out TO (OR AS A CONSEQUENCE OF): UNULY OUT TO (OR AS A CONSEQUENCE OF):											
NO	Sequentielly list conditions, Out TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS A CON	SEQUENCE OF).			,		Jeco's				
IF	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CON	SEQUENCE OF):									
Ë	resulting In death) LAST											
	PART II. Other significant conditions contr	lbuting to deeth but no	ot resulting in t	he underlyin	g ceuse given in	Part I. 24a. WAS AN PERFOR		. WERE AUTOPSY FINDINGS				
MEDICAL						1 YES 2		AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?				
Σ						_		1 TES 2 NO				
AN	25. WAS CASE REFERRED TO MEDICAL											
PHYSICIAN:	EXAMINER? HOSI	PITAL:		THER:	ACE OF DEATH (Che							
¥ I		le. DATE OF INJURY	2Sb. TIME O		e 5 Rasidence							
BY PI	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WC	URY AT PRK? YES 2 \(\) NO	28d. DESCRIBE HOW IF	NURY OCCURED					
_	3 Suicide S Could not be	e. PLACE OF INJURY — At building, etc. (Specify)	home, tarm, stree	t, factory, offic	•	281. LOCATION (Street a City or Town, State)	nd Number or Rural F	Route Number,				
H.	4 Homicide determined					3.7 5. 10.1.1, 510.157						
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To Description on the control of the certification of the							and manner en stated				
В В	2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)											
0	(Ulefr	rance	5		0010	F28	► 3/2	2/97				
2	30. NAME AND ADDRESS OF PERSON WHO COMPL						7	//~				
	MAX FRANK, M.D./7575 31. DATE FILEO (Month, Day, Year)	RITCHIE HIG	HWAY, S	.E./GL	EN BURNI	E, MARYLAN	D 21061					
	MAR 3 0 1993	lie Teviden 13	ords BB.					1				

for 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should intained by the hospital or attending physician.

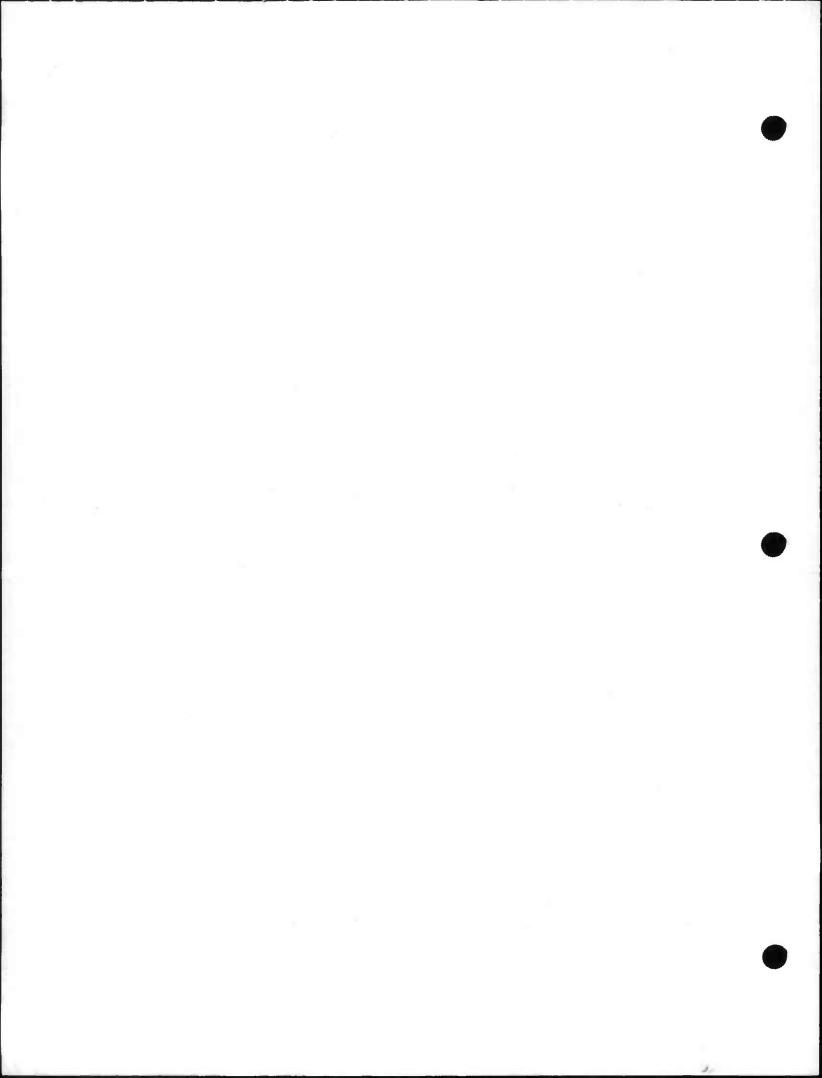
BALTIMORE MARYLAND 21215-0020 ter death. Rege stress) by mained by the hospital or attending physici TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frouts after death. Reserving the first provided by the attending physician and completely filled in by the tuneral difference of a mount by the attending physician and completely filled in by the tuneral difference of a mount be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,



		L.K.D.											9:	3 (18524
		1 - STATE REGISTRAR		STATE OF I	MARYLAN		ARTMEN IFICAT				MENT	AL HYGIEN	IE		
		1. DECEDENT'S NAME (First, OTIS	Middle, Last)		MERRITT TO MONTH DAY YEAR								3. TIME OF DEATH		
'''		4. SOCIAL SECURITY NUMBER 216 36 620		5. SEX	6. AGE (In)	yrs. last birthd	IF UNDE	R 1 YEAR	IF UNDER		7. DAT	25 TE OF BIRTH Smith, Day, Year) 18/37			
3 should		9a. FACILITY NAME (If not ins	titution, give s				9b. CIT	Y, TOWN C	OR LOCATI	ION OF O	_	/10/3/		NTY OF D	
38	OR	4261 ROKE		AD.			В	LTI	MOR	E C	ITY	•			
(is)	DIRECTOR	10a. STATE	10b. COUNTY	,	-	10c.	CITY, TOWN	OR LOCAT	ION				10d. INSIDE CITY		
13		Md.					Ba1	tim	ore				1 X YES 2 NO		
ti.	FUNERAL	100. STREET AND NUMBER 4261 F	lokob	D.a				101	. ZIP COD						HAT COUNTRY?
J Ician. al-trans	N N	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U	S. ARMED	13.	WAS DEC		229 De hispai	NIC ORIG	GIN? (Specify Ye	U.S		— American Indian,	
21215-0020 al or attending physician. for use as the burial-transit	B≺	1 Never Married 2 🖔 I 3 Widowed 4 Divor		FORCES? 1 ☐ YES 2 ☑NO IF YES, GIVE WAR OR DATES				If yes, sp	city Cube 2 X NO	in, Maxica	nn, Puert	o Rican, atc.)	3, 7,0	Special Bla	, White, atc.
	ETED	15, DECE (Specify only	DENT'S EDUC highest grade	CATION completed)	.10	Ba. DECEDEN (Give kind	of work done	during mo	ON st of working	ng	1	6b. KIND OF BU	SINESS/IND	USTRY	
yl_AND 21 by the hospital of the detached for all once.	COMPLE	Elamentary/Secondary (0-		College (1-4 or 5	Assembler New Cars				S						
YLAND d by the hospit id be detached d at once.	BE CO		ierri	tt, Sr.					1a MOTE	HER'S NA Liza	abet	t, Middle, Maiden th Dr	ake		
MARY be retained to e 5 should notified	10	Betty Lou		ritt									Town, State, Zip Code) 1to., Md. 21216		
BALTIMORE, MARYLAND ter death. Page 6 may be retained by the hospit the funeral director, page 5 should be detached hail.		20s. METHOD OF DISPOSITION 1	3 Rem	oval from Stata n t om ome		ACE AND DA			me of				cation -		
TIM . Page ral din		21. SIGNATURE OF FUNERAL					22	NAME AN	D ADDRE		CILITY				
BALTIMO after death. Page 6 by the funeral directo noval.		Came		100	sto	N									d.21217
B nours after of in by the or removal			art fellure.	complications the List only one cau	it caused thuse on each	ha daeth. D h line.	o not ante	r tha mo	de of dy	ing, suc	th as ce	erdiac or reap	iretory en	rest,	Approximate Interval Between
24 / fille tion,		iMMEDIATE CAUSE (Find disease or condition resulting in death)		DUE TO (OR AS A CONSCOUENCE OF):									Onset and Death		
(68760, executed within and completely o burial, crema matic event,	z														
Sician Sician traum	CATIO	Sequentially list condition if any, leading to immed cause. Enter UNDERLYIN	ONSEQUENCE	OF):						-					
certifica ding phr lygiene	CERTIFICATION	CAUSE (Disease or Injur that initiated events resulting in dasth) LAST		DUE TO (OR AS A CONSEQUENCE OF):											
e dea he at Menta jury,		PART II. Other algorifican	t condition	contributing to death but not resulting in the underlying cause given in P					Dart I	I are who are	AllToney	T 0.15	WEST ALITONOM THE MAN		
and	MEDICAL	CACHEXI			- dualit bot	not readitu	y in the u	nuerrying	Cause	Aran III	ranti.	PERFOR	24a. WAS AN AUTOPSY PERFORMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
REC requires seen sign of Heali												PORTIN	L		1 YES 2 NO
- e g e c	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEOICAL					26. PL	ACE OF 0	EATH (Ch	eck only	one)			
VITA VITA SIAN: The critificate h he State (YSIC	N☐ YES 2 ☐ NO		HOSPITAL:	☐ ER/Outpatia	ant 3 🗆 DO/	OTHE 4 - Nu	R: sing Hom	5 (X)Pa	sidence	6 🗆 Oti	her (Specify)			
PHYSIC PHYSIC WITH IT WITH IT	ву Рн	27. MANNER OF OEATH 1 Natural 5 P 2 Accident In	ending westigation	28a. OATE OF (Month, D		28b.	IME OF INJURY M	28c. INJI WO 1 _ Y		□ NO	28d. D	ESCRIBE HOW I	NJURY OC	CURED	
OR ATTENDING OR ATTENDING DIRECTOR: After hours after death item 28 is mai	ETED I		ould not be stermined	28a. PLACE C building,	of INJURY — intc. (Specify)	At home, fan	n, street, fac	tory, office			281. LC	OCATION (Street try or Town, State)	and Number	or Rural R	oute Number.
로로인트	COMPLE			CIAN: To the best of											and manner as stated.
THE HOSPITAL THE FUNERAL filed within 72 I		296. SIGNATURE AND TITLE						1		ENSE NUM		ne and piece, an			
TO THE HOSPI TO THE FUNER be filed within	TO BE	30. NAME AND ADDRESS OF	MY Y	how COMPLETED CALL	SE OF OFATH	(ITEM 27) (I	The Print			C.M		·	≥9d. DATE SIGNED (Month, Dey, Year) ►03/25/1993		
		MARAMIN 1	J.KOR	ELL jum	111	Penr		eet	, Ва	alti	mo1	ce, Ma	ryla	ınd	21201
		MAR 3 ()	1993	32. REGISTRA			L								
		to one one		U											DHMH-18 Rev 1/8



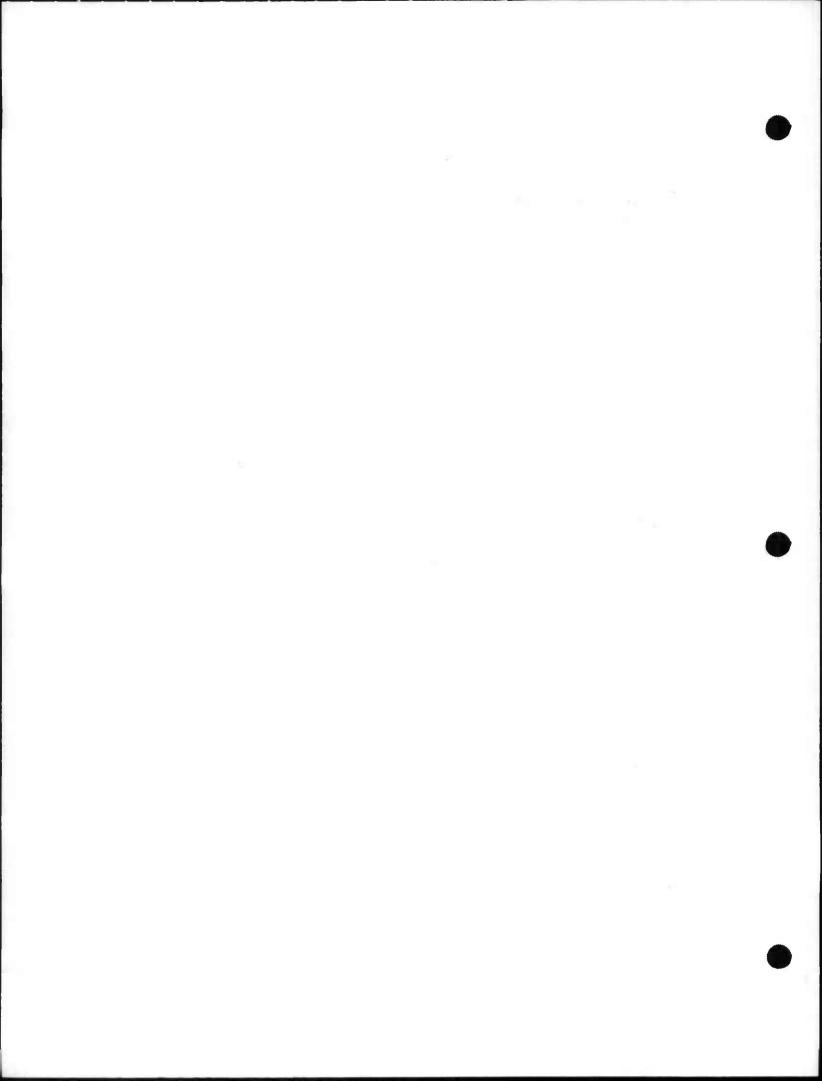
entimeter physician.	use with buria-transit permit. Pages 1, 2, 3 should)
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital of	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use that have been signed befined within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

			IENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.		00020					
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	V VEAR	3. TIME OF DEATN					
	Daniel Myles			03 28	93	2 A W					
	4. SOCIAL SECURITY NUMBER 3. SOCIAL SECURITY NUMBER 3. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. In 1914 2 - F 58)		UNDER 1 YEAR IF UNDER 24 HRS. ITHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 12 05/34	(Month Day Year) Country)						
DIRECTOR	5+ella Maris Hospice	96.	CITY, TOWN OR LOCATION OF DE	ATH	Baltin						
EG	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c. CITY, TO	OWN OR LOCATION			10d, INSIDE CITY					
	Md.	Bal	ltimore			LIMITS?					
¥.	10s. STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?					
FUNERAL	3131 Windsor Blvd.		2/20	7		USA					
BY FU	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1. 9 5 8	RMED NO	13. WAS DECENDENT OF NISPAN If yes, specify Cuban, Mexices 1 YES 2 NO Specify	n, Puerto Ricen, etc.)	or No — 14. RACI Black Spec						
8	15. DECEDENT'S EDUCATION 16e. D	ECEDENT'S USU	AL OCCUPATION done during most of working	16b. KIND OF BUSI	INESS/INDUSTRY	Black					
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	fe. Do NOT use ret	lred.)	l							
Ř	17. FATNER'S NAME (First, Middle, Last)	Stee1	worker		hem St	eel					
	James Gray			ME (First, Middle, Maiden S	,						
BE		9b. MAILING AD	DRESS (Street end Number or Rural F	Sie Myles Oute Number City or Town							
임	Louise Myles		Windsor Blad			21207					
	20a. METNOD OF DISPOSITION 1 ⚠ Buriel 2 ☐ Cremation 3 ☐ Removal from State	EANDDATEGED	SPOSITION (Name of	0ATS 20c LOC	ATION — City or To	own, State					
	4 Donation 5 Other (Specify) Chic	ef Cor	nerstone Cen		ochlano	d Co., Va.					
	Jamesa Mosta		James A. N		Song						
	and the second s		1/01 Laur	ens St.	Balto.	Md.21217					
	23. PART/I, Enter the diseases, or complications that caused the death. Do not enter the mode of dying, euch as cardiec or respiratory arrest, shock, pr heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Onset and Death Onset and Death										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
AL C	PART II. Other significent conditions contributing to death but not	resulting in th	e underlying cause given in i	Part I. 24s. WAS AN A	WTOPSY 24h	. WERE AUTOPSY FINDINGS					
PHYSICIAN: MEDICA				PERFORM 1 YES 2	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
Ă	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF OEATH (Che	ck only one)							
JS	HOSPITAL: 1 PES 2 NO 1 Inpetient 2 ER/Outpetient :		HER: Nursing Home 5 - Residence	Other (Specify)	HOSPI	CE					
ву РН	27. MANNER OF DEATN 1 Neturel 5 Pending 2 Accident Investigation	26b. TIME OF INJURY	28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE NOW IN							
	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — Af he building, etc. (Specify)	ome, farm, atreet	, fectory, office	261. LOCATION (Street en City or Town, State)	nd Number or Rural F	Route Number,					
3 Success 8 Could not be detarmined building, etc. (Specify) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(e) end manner as stated.											
TO BE	296, SIGNATURE AND TITLE OF CERTIFIER Cacles A Clefards	10	D27	087	≥ 3/2	(Month, Day, Year) 9/93					
	30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITE	M 27) (Type, Print)								
	31. DATE FILED (Month, Day, Yber) MAR 3 0 1993 June Davidson-Ren	nde ss									



BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.	TEN	TOR:
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death ce	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attendit be filed within 72 hours after death with the State Dept. of Health and Mental Hy.
	2	23

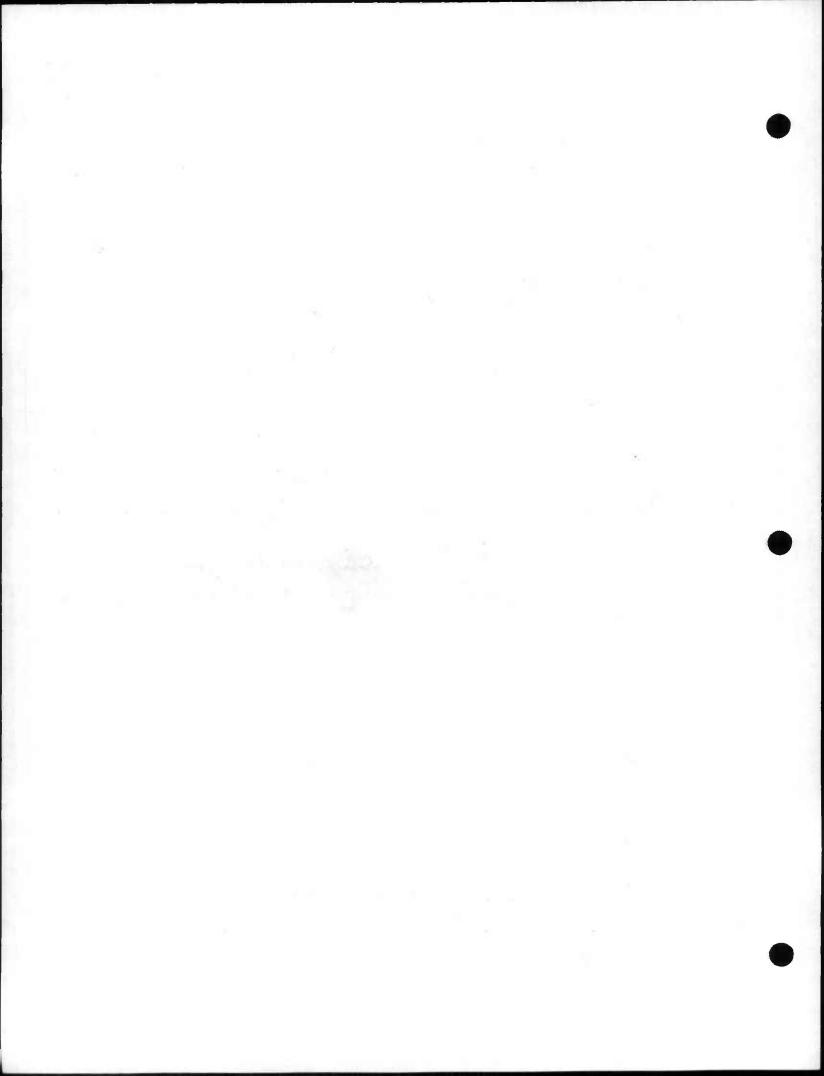
							9	3 (18526			
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND	DEPARTM	ENT OF	HEALTH AN		łE .		,0020			
	1. DECEDENT'S NAME (First, Middle, Last)		ERTIFICA	ALE OF	DEATH	REG. NO).					
	ROBERT H.G.	MACKENZIE					3 -	93	3 A . M			
		S. SEX 6. AGE (In yrs. la.	si birthday) IF U	INDER 1 YEAR	IF UNDER 24 HR			8. BIRTHPL Country)	ACE (State or Foreign			
	220-09-5704 9e. FACILITY NAME (If not institution, give stree	M 2 F 84	YRS.			11-13-0			MD.			
e B	717 EVESHAM AV		96.	BAL'	OR LOCATION OF	DEATH	9c. COU	NTY OF DEA	TH			
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY											
DIRECTOR			10c. CITY, TO		TION			10	Dd. INSIDE CITY LIMITS?			
1	MD . 10e. STREET AND NUMBER		BA	LTO.				1	YES 2 NO			
FUNERAL				10	1. ZIP CODE				AT COUNTRY?			
R	717 EVESHAM AV				2121			.S.A	•			
	1 Never Merried 2 Merried	2. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2	MED	13. WAS DEC	CENDENT OF HIS	PANIC ORIGIN? (Specify Yesticen, Puerto Rican, stc.)	e or No—	14. RACE -	American Indian, Vhite, atc.			
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES				ecify:	i	Specify:				
8	15. DECEDENT'S EDUCAT	ION 160 DE	CEDENT'S USUA	U OCCUPATI	001		- 1		WHITE			
	(Specify only highest grade cor	mpleted) (G	ive kind of work d . Do NOT use retir	lone during me	ost of working	16b, KIND OF BU	SINESS/INC	DUSTRY				
Elementary/Secondary (0-12) College (1-4 or 5 +) 2yrs. METALURGIST ARMCO STEEL												
COMPLET	17. FATHER'S NAME (First, Middle, Last)					NAME (First, Middle, Maiden						
BE (GEORGE N. MACK	KENZIE			PO	BERTA MAY	MADE	TD				
	19e. INFORMANT'S NAME (Type/Print)		b. MAILING ADDI	RESS (Street a		ral Route Number, City or Tow						
욘	CLINTON G GLAS					E. BALTO.			2.			
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remova	20b. PLACE	AND DATE OF DIS	POSITION (Ne	eme of	DATE 20c. LC	CATION -	City or Town,	State			
	4 Donation 5 Other (Specify)	Comotory, Cre	AND PR		. CEM.				LE, MD.			
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE			NO ADDRESS OF							
	· William K	· laves III	_	490)5 YOR	JENKINS K RD. BAL	то	MD.). 21212.			
	23. PART I. Entar the diseases, or com- shock, or haert failure. List	iplications that caused the de t only one cause on each line	ath. Do not er	ntar the mo	da of dying, s	uch as cardiac or resp	ratory arr	eat,	Approximata			
	IMMEDIATE CAUSE (Final	1)	. /	-					Interval Batween Onset and Daath			
- 3	disease or condition resulting in death)											
	Onset and Death Conset and Death											
Z	Samurable Had an elist	Vantricu	arane	LIVIA	m-ac	ute trinoca	1:0	Sug.	107111			
FICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEC	DUENCE OF):	0		7	ZHAV.	Trug.	10 gra.			
2	CAUSE (Disease or Injury							U				
E	that initiated events	DUE TO (OR AS A CONSEC	OUENCE OF):									
6	resulting in death) LAST											
O	PART II. Other significant conditions c	ontributing to death but not a	aculting in the	are deed de								
MEDICA		entitle and the first had the first h	cauting in the	underryin	g cause given	In Part I. 24a. WAS AN PERFOR		AW	RE AUTOPSY FINDINGS AILABLE PRIOR TO			
0						1 🗆 YES 2	NO NO		MPLETION OF CAUSE DEATH?			
								1 [YES 2 NO			
Z												
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	OTI	28. PL	ACE OF DEATH (Check only one)						
YS	1 YES 2 NO	Inpetient 2 ER/Outpetient 3			e 5 Residenc	8 Other (Specify)						
표	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJ WO	URY AT RK?	28d. DEŞCRIBE HOW II	NJURY OCC	URED				
BY	1 Natural 5 Pending 2 Accident Investigation		N	1 0								
	3 Suicide 8 Could not be	28e. PLACE OF INJURY — At hor building, etc. (Specify)	ne, ferm, atreet,	fectory, office		28f. LOCATION (Street a City or Town, State)	nd Number	or Rural Route	Number,			
COMPLETED	4 Homicide determined					Grif or rown, State)						
교	290. CERTIFIER 1 CERTIFYING PHYSICIAN	: To the beat of my knowledge, de	ith occurred at the	he time, date	end place, and de	ue to the causa(a) and man	ner ee stet-	ud.				
No.	one) 2 MEDICAL EXAMINER: O	n the beels of examination end/or in	nvestigation, in n	ny opinion, d	eath occured at the	ne time, date end place, en	d due to the	cause(s) en	d menner on stated			
Ü	296. SIGNATURE AND TITLE OF CERTIFIER,		0 =		29c. LICENSE N							
. 447 11	Henry DA	(1	Da C	¥	DO 42.			SIGNED (Mo	nth, Day, Year)			
TO B	1000	0001	- Park 1						/ - A-			

N JR. M.D. 350

3506 N. CALVERT ST. BALTO., MD 21218.

WILLIAM P. BE 31. DATE FILED (MONTH, Day, Year) MAR 3 0 1993 BENSON JR. 32. REGISTRAR'S SIGNATURE

Lulia Davidson Randalle



29d. DATE SIGNED (Month, Day, Year)

DIVISIC TO THE HOSPITAL OR ATTEND TO THE FUNERAL DIRECTOR: A be filed within 72 hours after of IMPORTANT: If Nem 28 is

BE

9

0

29b. SIGNATURE AND TITLE OF CERTIFIER

1 - STATE

								UF DEA			i. NO.			
		1. DECEDENT'S NAME (First, M.	Aiddle, Last)						T	2. OATE OF DEA			13	TIME OF DEATH
		LOUISE H	R M2	CHEN					i	MONTH	DA		YEAR	I'ME OF DEATH
		4. SOCIAL SECURITY NUMBER		5. SEX	A ACE (I	yrs. last birthday)				3 –		5 –9		6:40 F H
				10	O. AGE (III	1034	MONTHS D	EAR IF UNDER AYS HOURS	MIN.	7. DATE OF BIRT (Month, Day, Y			8. BIRTHPL Country)	ACE (State or Foreign
P		192-26-846		1 M 2 X F		77 YRS.				2-16	-16	5		MD.
should		9a. FACILITY NAME (If not institt	tution, give st	treet and number)			9b. CITY, TO	WN OR LOCATION	ON OF OEA	ATH .		9c. COUN	TY OF DEA	гн
2, 3	OR	COLLEGE N	MANOI	R INC.									BALT	0
-	CTO	RESIDENCE OF DECE	DENT										DALL	0.
Pages	뿐	10a. STATE	10b. COUNTY	•		10c, CIT	Y, TOWN OR L	OCATION					10	d. INSIDE CITY
ند	<u> </u>	MD.	BAI	LTO.			тлтни	ERVILL	E				- 1.	LIMITS?
permit.	AL AL	10e. STREET AND NUMBER	Dill	SIO.			201111	101. ZIP CODE			_	40 0.70		
	ER/	000						1 1000				- 1 -		T COUNTRY?
020 physician. burial-transit	2	300 W. SI	EMINA						.093				.S.A	•
20 nysic		1 Never Married 2 Ma	amind	12. WAS DECEDEN FORCES? 1	YES	U.S. ARMED	13. WAS	DECENDENT O	F HISPANIC	C ORIGIN? (Speci	Ify Yes	or No-	14. RACE -	American Indian,
the pt		3 Widowed 4 Divorce		IF YES, GIVE W	MAR OR DAT	ES		YES 2 NO		, Maxican, Puerto Rican, atc.) Specify: WH				
215-0020 attending physician se as the burial-trar	2							-				ŀ		WHITE
	E	15. DECEDI (Specify only hi	DENT'S EDUC	CATION completed)		16a. DECEDENT'S	(GIVE KIND OF WORK done during most of working					NESS/IND	USTRY	
21 a or for u	m l	Elementary/Secondary (0-12)		College (1-4 or 5	+)	life. Do NOT u	se retired.)	ng most or worken	ng .					
	릴			6yrs,	·	HOME	MAKE	•			НΟ	TEMA	KED	
MARYLAND retained by the hospit 5 should be detached notified at once.	COMPLET	17. FATHER'S NAME (First, Middl	Ile, Last)			пои	HAREI		15010 NAME				ILEK	
YLA by the be det										E (First, Middle, M				
MARYL retained by the should be notified at	띪	THOMAS C		ACHEN						VELIA				
MAR retained 5 should notified	2	19a. INFORMANT'S NAME (Type	,			19b. MAILING	ADORESS (St	reat and Number	or Rural Ro	oute Number, City	or Town	State, Zip	Code)	
	-	ARTHUR W.	MACI	HEN, JR.		SHITTE	1800) 2нов	KTNS	S PLAZ	A 1	RAT.T	O.MD	21201.
ORE, P 6 may be octor, page 6 must be n		20a, METHOD OF DISPOSITION			20b. F	LACE AND DATE			IV I IV				City or Town	
O o u	examiner must	1 M Buriel 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (Sp		oval from State	cemer	tery, crematory or o	ther plece)							
Page al direc		21. SIGNATURE OF FUNERAL S		FNSFF	G	REENMO				3/30	B	ALTO	.,MD	•
BALTIMORE, ter death. Page 6 may be the funeral director, page val.			. /	1	-		22. NAN	E AND ADDRES		. JENK	TM	2 2	COMC	CO
4 - 6		W. UUIAn	mK	VAIRE	2111									
a ye a	-	23. PART I. Enter the disease	eses, or c	omplications that	t couned :	the deeth Do	ot antes the	4905	101	KK KD.	B	ALTU	. , MD	. 21212.
hours or re		ahock, or hear	rt fallure. L	ist only one ceu	ise on eac	ch line.	ior enter the	mode or dyn	ng, such	as cardlec or	respin	story arre	eat,	Approximate Interval Batween
		IMMEDIATE CAUSE (Finel			^					0				Onset end Death
- de 10		disesse or condition resulting in death)		0 1	Le.	SPIN	1000	7 /~	ter	trem				day
760, ed within ompletely II, cremati								/ "						
	z	Total In County		DUE TO	(OR AS A C	CONSEQUENCE OF	F): /							
	S			DUE TO	(OR AS A C	CONSEQUENCE OF	F): /	(0)	00					1
exec exec to bu	의	Sequentielly list conditions		DUE TO	(OR AS A C	SP 1 - CONSEQUENCE OF	F): /	COP	00					
OX 6 be exected incident and trior to by traumat	ATIC	Sequentielly list condition if any, leading to immediate	na, ate	DUE TO	(OR AS A C	CONSEQUENCE OF	F): /	COF	00				<u> </u>	
BOX 68 ficate be execut physician and c ne prior to buria	FICATIO	Sequentielly list conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury	na, ate	DUE TO	(OR AS A C	CONSEQUENCE OF	7):	COP	00			-		
O. BOX 6 certificate be execting physician and ygiene prior to by other traumat	ITIFICATIO	Sequentielly list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events	na, ate	DUE TO	(OR AS A C	CONSEQUENCE OF	7):	COP	00					
5.0. BOX h certificate be a nding physician a Hygiene prior to or other traum	ERTIFICATIO	Sequentielly list conditions if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury	na, ate	DUE TO	(OR AS A C	CONSEQUENCE OF	7):	COP	00			-		
5.0. BOX h certificate be a nding physician a Hygiene prior to or other traum	- CERTIFICATION	Sequentielly list condition if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST	G C	DUE TO	(OR AS A C	CONSEQUENCE OF	-): -):							
RDS, P.O. BOX It the death certificate be a by the attending physician a nd Mental Hygiene prior to Injury, or other traum	AL CERTIFICATION	Sequentielly list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events	conditiona	DUE TO	(OR AS A C	CONSEQUENCE OF	r): r): In the under			art I. 24e. W	S AN A	UTOPSY		RE AUTOPSY FINDINGS
RDS, P.O. BOX It the death certificate be a by the attending physician a nd Mental Hygiene prior to Injury, or other traum	DICAL CERTIFICATION	Sequentielly list condition if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST	conditiona	DUE TO	(OR AS A C	CONSEQUENCE OF	r): r): In the under			art I. 24a. W	S AN A	ED?	AM CC	MILABLE PRIOR TO MPLETION OF CAUSE
CORDS, P.O. BOX res that the death certificate be a signed by the attending physician is eath and Mental Hygiene prior to vs any injury, or other traum	EDICAL	Sequentielly list condition if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST	conditiona	DUE TO DUE TO	(OR AS A C	CONSEQUENCE OF	in the under	lying ceuse g		art I. 24e. W	S AN A	ED?	AM CO OF	MILABLE PRIOR TO MPLETION OF CAUSE DEATH?
CORDS, P.O. BOX res that the death certificate be a signed by the attending physician is eath and Mental Hygiene prior to vs any injury, or other traum	MEDICAL	Sequentielly list condition if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in death) LAST	conditiona	DUE TO	(OR AS A C	CONSEQUENCE OF	in the under	lying ceuse g		art I. 24a. W	S AN A	ED?	AM CO OF	MILABLE PRIOR TO MPLETION OF CAUSE
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ON OF VITAL RECORDS, P.O. BOX ING PHYSICIAN: The law requires that the death certificate be e. After this certificate has been signed by the attending physician stath with the State Dept. of Health and Mental Hygiene prior to marked, or Item 23 shows any injury, or other traum	BY PHYSICIAN: MEDICAL	Sequentielly list conditions if any, leading to immedia cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significent of the condition of the condit	acconditions C A AEOICAL	DUE TO DUE TO a contributing to Capa HOSPITAL: Inpatient 2 2ee. DATE OF (Morth, De	(OR AS A CO	CONSEQUENCE OF	OTHER: 4 Nursing	lying ceuse g 6. PLACE OF DE Home 5 Rec INJURY AT WORK? YES 2	EATH (Check eldence 6	art I. 24e. We PE 1 YI YI K only one)	IS AN A REFORM ES 2 [NO NO	AM CCO OF	NLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
ON OF VITAL RECORDS, P.O. BOX ING PHYSICIAN: The law requires that the death certificate be e. After this certificate has been signed by the attending physician stath with the State Dept. of Health and Mental Hygiene prior to marked, or Item 23 shows any injury, or other traum	D BY PHYSICIAN: MEDICAL	Sequentielly list condition: If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in death) LAST PART II. Other significent of the significant of	CONDITIONS AEOICAL AEOICAL Inding eatigation uld not be	DUE TO DUE TO Contributing to	(OR AS A CO	CONSEQUENCE OF	OTHER: 4 Nursing	lying ceuse g 6. PLACE OF DE Home 5 Rec INJURY AT WORK? YES 2	EATH (Check eldence 6	art I. 24a. We PE 1 YI	S AN A RFORM RES 2 [NO NO	AM CCO OF	NLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
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DIVISION OF VITAL RECORDS, P.O. BOX OR ATTENDING PHYSICIAN: The law requires that the death certificate be a DIRECTOR: After this certificate has been signed by the attending physician incours after death with the State Dept. of Health and Mental Hygiene prior to them 28 is marked, or iftem 23 shows any injury, or other traum	ETED BY PHYSICIAN: MEDICAL	Sequentielly list condition if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significent of the condition of the cause of	conditions Conditions AEOICAL Auding eatigation uid not be earmined	DUE TO DUE TO Contributing to	(OR AS A C (OR AS A C (OR AS A C death but ER/Outpat! INJURY sy, Year) F INJURY stc. (Specify	CONSEQUENCE OF	OTHER: 4 Nursing E OF 28c. URY M 1	S. PLACE OF DE Home 5 Rec INJURY AT WORK? YES 2	EATH (Checkeldence 6	art I. 24a. WPPE 1 YI 1 YI WOTHER (Specify City or Town,	S AN AN ARFORM	NO N	AM COO OF 1 [NILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
ON OF VITAL RECORDS, P.O. BOX ING PHYSICIAN: The law requires that the death certificate be e. After this certificate has been signed by the attending physician stath with the State Dept. of Health and Mental Hygiene prior to marked, or Item 23 shows any injury, or other traum	TED BY PHYSICIAN: MEDICAL	Sequentielly list condition if any, leading to immediat cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST PART II. Other significent of the condition of the cause of	conditions C d AEOICAL AEOICAL July and the designation of the des	DUE TO DUE TO Contributing to	(OR AS A C	CONSEQUENCE OF CONSEQ	OTHER: 4 Nursing E OF 28c, M 1 dat the time,	S. PLACE OF DE B. PLACE OF DE	EATH (Checkeldence 6	art I. 24a. We PE 1 YI	S AN A REFORM ES 2 [O ON IN. State)	INO NO JURY OCCI d Number of	AMOUNT OF THE PROPERTY OF THE	NLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO

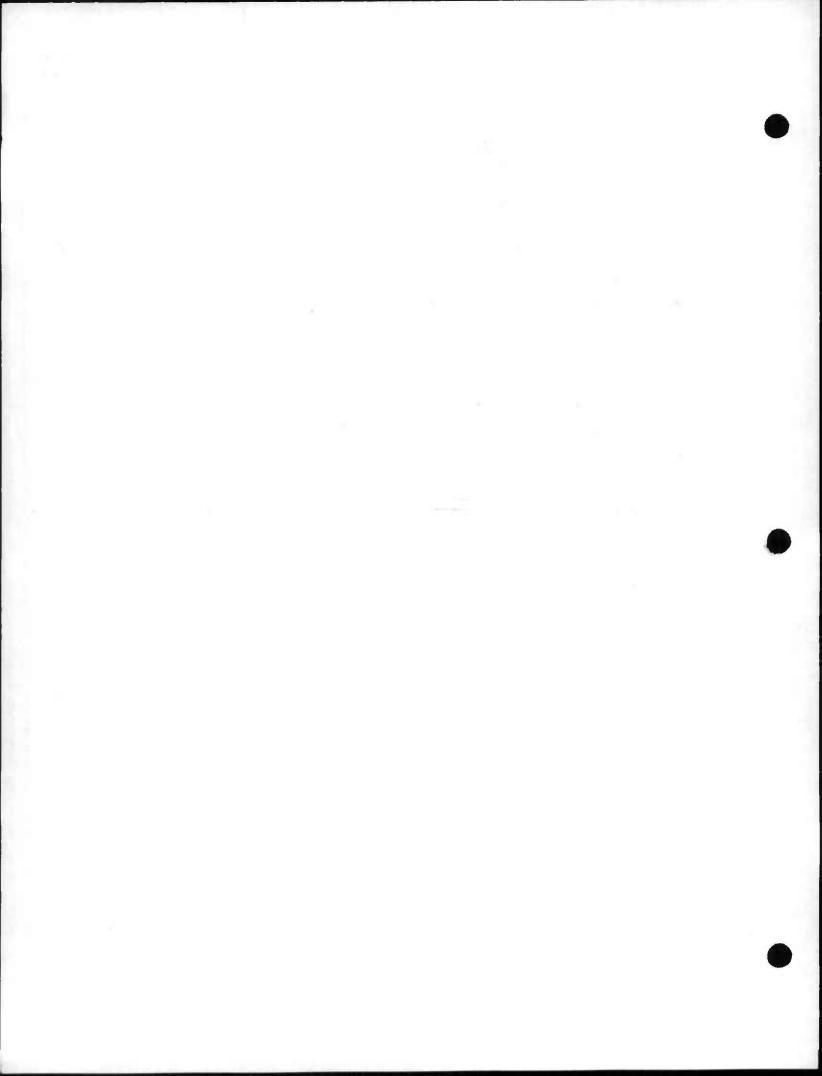
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TIMOTHY SOUWEINE M.D. 1134 YORK RD. LUTHERVILLE, MD. 21093. MAR 3 0 1993 32 REGISTRAR'S SIGNATURE Grina Davidson Randa

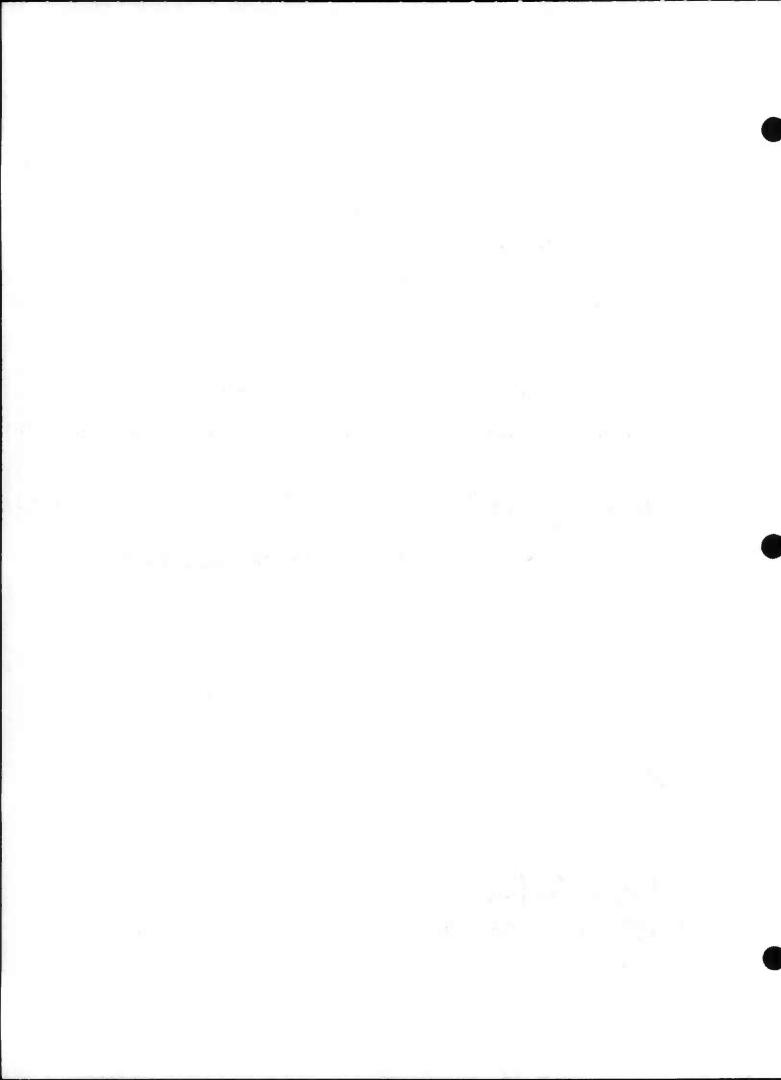
29c. LICENSE NUMBER

024732

Lev



		1 - STATE REGISTRAR	STATE OF MARYLAND / DEPA	RTMENT OF HEALTH AND FICATE OF DEATH	MENTAL HYGIENE REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY	YEAR 3. TIME OF DEATH
		JOHN 4. SOCIAL SECURITY NUMBER	CHARLES 5. SEX 6. AGE (In yrs. lest birthday	MARBURGER) IF UNDER 1 YEAR IF UNDER 24 HRS.	03 26 7. DATE OF BIRTH	93 4:05 PM
pin		218-01-9103	1X M 2 □ F 77 YRS.	MONTHS DAYS HOURS MIN.	02/19/16	BALTO., MD
1, 2, 3 should	CTOR	ANNE ARUNDEL H		96. CITY, TOWN OR LOCATION OF D		INTY OF DEATH NE ARUNDEL
iges 1.	l w	10a. STATE 10b. COUNTY	10c. C	ITY, TOWN OR LOCATION		10d, INSIDE CITY
permit. Pages	I BIO		LTIMORE	CATONSVILLE		1 YES 2 X NO
in.	FUNERAL	10e. STREET AND NUMBER 4 MOUN	T DE SALES RD.	101. ZIP CODE 2 1 2 2 9		USA
5-9020 idea perda	₽	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES YNO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic: 1 YESY NO Specific		14. RACE — American Indian, Black, White, atc. Specity: WHITE
arte use a	ETED	15. DECEDENT'S EDUC (Specify only highest grade	completed) (Give kind or	S USUAL OCCUPATION f work done during most of working	16b. KIND OF BUSINESS/IN	
	PLE	Elementary/Secondary (0-12) 8th	College (t-4 or 5 +) MATNTE	uso rotirod.) NANCE MECHANIC	UNION CAR	RIDE
LA a a a	at once.	17. FATHER'S NAME (First, Middle, Lest) CHARLES E. M.		18. MOTHER'S NA	ME (First, Middle, Maiden Surname) BERTHA	3101
		19a. INFORMANT'S NAME (Type/Print)		IG ADDRESS (Street and Number or Rural		(c Code)
	TO BI	DOROTHY E. MAR				LLE, MD. 21229
W > 2	must be	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Rame		OF DISPOSITION (Name of pitter place)		City or Town, State
Page 6 may all director, pa		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC		HEDRAL CEM.		MORE, MD.
	ехатіпет	1 Javil a	(e) der	DAVID J. WE	BER F.H.	LTO., MD 21229
aft on	medicai	23. PART I. Enter the diseases, by c	omplications that caused the death. Do			reat, Approximate
within 24 hou apletely filled in cremation, or	event, the me	IMMEDIATE CAUSE (Final	OUE TO (OR AS A CONSEQUENCE OF	DOUTHURL DORT	L DYGURY	Interval Between Onset and Death
P.O. BOX 68 th certificate be execu- ending physician and I Hyglene prior to bur	or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	OUE TO (OR AS A CONSEQUENCE (
RECORDS equires that the cen signed by the of Health and Me	MEDICAL	PART II. Other algnificant conditions	contributing to death but not reaulting	In the underlying cause given in	Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 VES 2 NO	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AL F le law r has be Dept.	Item 23 s	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEATH (Ch	ack anh ann	
VITA AN: The Ufficate ha	PHYSICIAN:	EXAMINER?	HOSPITAL: 1 ☐ inpatient 2 M ER/Outpatient 3 ☐ DOA	OTHER: 4 Nursing Home 5 Residence		
PHYSICIA r this certil		27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year) 28b. TII		28d. OEŞCRIBE HOW INJURY OC	CURED
SI Figure	Z8 Is mar TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — At home, farm, building, atc. (Specify)	street, factory, offica	281. LOCATION (Street and Number City or Town, State)	v or Rural Route Number,
- 4 4 5	ANT: If Item 28 COMPLETE		IAN: To the best of my knowledge, death occur			
HOSP! FUNEF	CO	29b. SIGNATURE AND TITLE OF CERTIFIER	I: On the basis of examination and/or investigati			
TO THE HOSPITAL OF TO THE FUNERAL DO THE FUNERAL DO THE FUNERAL DO THE FUNERAL DO THE WITHIN 72 TO THE FUNERAL DO THE FUNERAL FUNER	TO BE	Marie 1	Youle	O.C.M		TE SIGNED (Month, Day, Year) -28-1993
	-	MARyamon A	- CORDUM 111 P		altimore, Ma	ryland 21201
		MAR 3 0 199	32. REGISTRAR'S SIGNATURE 32. WE DEVILOP - Randa	R.		



OF DEATH? 1 | YES 2 | NO

29d. DATE 9IGNED (Mpnth, Day, Year)

93

241

▶ 3

21222

Approximate Interval Between **Onset and Death**

Maryland

BALTIMORE, MARYLAND 21215-0020

PHYSICIAN: MEDICAL

BY

COMPLETED

2

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

77	Em: 7 per pla	one (Tall									93	08529
	1 - FOR STATE REGISTRAR	193 EEPS		MARYLA	ND / D CEF	EPARTM	ENT OF	HEALTH F DEA	AND I	MENTAL HYO	IENE . NO.		
	1. OECEDENT'S NAME (First, MIC	ddle, Last)	20021	nsk	4	,					TH DAY C	YEAR 3	3. TIME OF DEATH
	218-03-8041 1 D M 2 X F				yrs. lest bi		UNDER 1 YEA	_	R 24 HRS.	7. DATE OF BIRTH 85 05			HPLACE (State or Foreign Marylan
TOR TOR	9a. FACILITY NAME (If not institu	1 ent	9b		or located.dle					ieath O			
DIRECTOR	RESIDENCE OF DECEDENT 10s. STATE 10s. COUNTY Maryland Baltimore					10c. CITY, TOWN OR LOCATION Dundalk							
FUNERAL	100. STREET AND NUMBER South 48 tl	h St	reet 12	238				10f. ZIP COI 212			100		States
B	11. MARITAL STATUS 1 Never Merried 2 Mar 3 Wildowed 4 Divorced	U.S. ARME 2X NO TES	NO If yes, specify Cuban, Mexican, Puerto Rican, etc.) Black,						E — American Indian, ik, White, atc.				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5					DENT'S USI kind of work o NOT use re SEMD	done during tired.)	most of work	dng		kay M		3
BE CON	17. FATHER'S NAME (First, Middle					stel	ME (First, Middle, A	Meiden Surname) Kna	ck				
TO B	19a. INFORMANT'S NAME (Typo/Print) Rosalie Petrush									Route Number, City et 1238			Md. 212
	200. METHOD OF DISPOSITION 130 Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 200. PLACE AND DATE OF DISPOSITION (Name Date of Disposition (Name Sacreptage demandage of Jesus 3/31 Dundalk, Ma												
	21. SIGNATURE OF FUNERAL SI	REPUICE LIC	P. Ran	rack	li					Chojna Ave.			P.A. 4d. 21224
	Elliste Con-	rt feilure.	complications the List only one ca	et caused use on ee	the dest	h. Do not	enter the	mode of d	ying, suc	h ae cerdiac or	reepiratory e	rrest,	Approximate Interval Betwee Onset and De-
	iMMEDIATE CAUSE (Final disease or condition reaulting in deeth)		a. RESP	OR AS A			AIL	RE					
ERTIFICATION	Sequentielly list condition If eny, leeding to immedie cause. Enter UNDERLYING CAUSE (Disease or Injury	ete G	b. 04 DUE TO	0 (OR AS A	CONSEOU	ENCE OF):	FI	4160	RI	gardin Ameliana Gardini			
ERTIF	that initiated events resulting in deeth) LAST	CONSEOU	ENCE OF):										

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 1 - YES 2 - NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO ient 2 - ER/Outpatient 3 - DOA ne 5 🗆 Residence 8 🗆 Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCUREO 1 Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide inco

29c. LICENSE NUMBER

102966

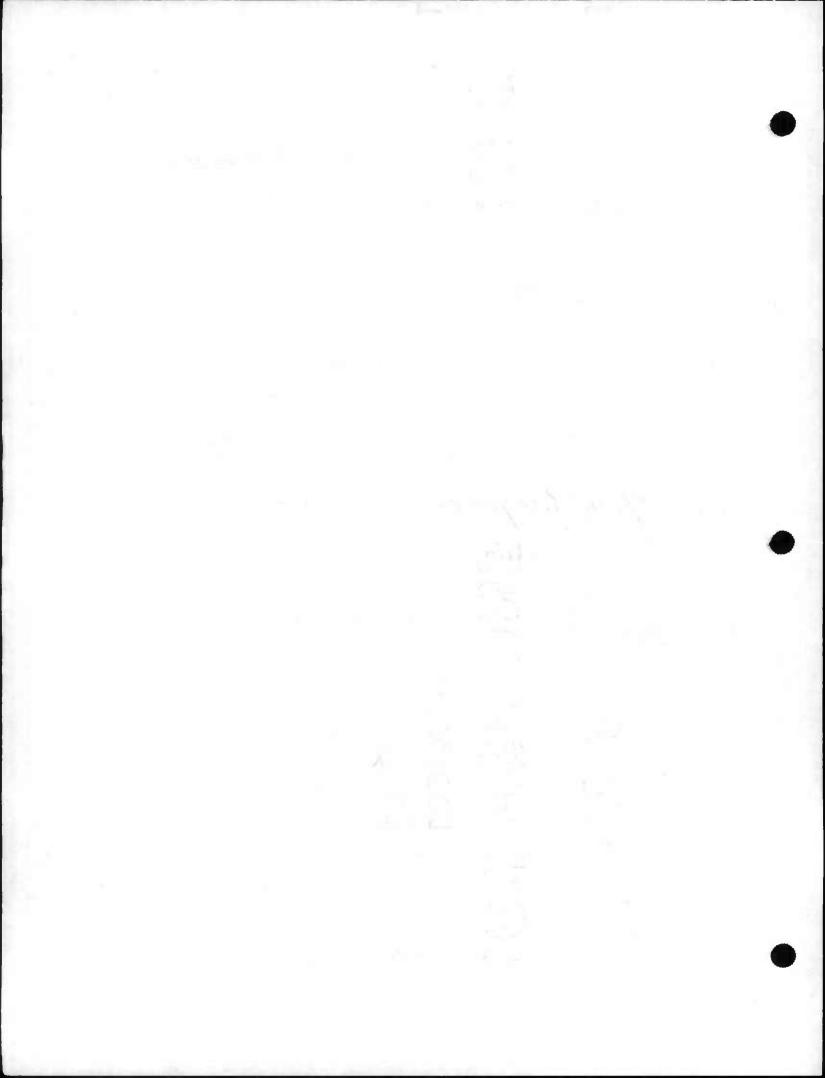
arra 6 IESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

3007 E. Northern Pkwy. Baltimore, Celiar Parra M.D

MAR 3 () 32. REGISTRAR'S SIGNATURE 1993

296. SIGNATURE AND TITLE OF CERTIFIER

while Davidson Randall



		1 - STATE REGISTRAR	STATE UF MAI	CE	RTIF	ICATE	OF			MENTAL	REG. NO.		7	
		1. DECEDENT'S NAME (First, Middle, Las CHARLE	> m	OKKIS	MO	rris	on			2. DATE O MONTH	F DEATH DA		YEAR 3.	TIME OF DEATH
_	19	4. SOCIAL SECURITY NUMBER 209-01-6770	5. SEX 6.	AGE (In yrs. last	birthday) YRS,	IF UNDER	1 YEAR DAYS	IF UNDER HOURS	24 HRS. MIN.	7. DATE OF			Country)	erick MD
2, 3 should	OR	9a. FACILITY NAME (If not institution, give CHURCH HOSPI						R LOCATION MORI				9c. COUN	TY OF DEAT	
permit. Pages 1, 2	DIRECTO	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN MD	TY		10c. CIT	Y, TOWN O	R LOCAT	ION						d. INSIDE CITY LIMITS?
		10e. STREET AND NUMBER						ZIP CODE					EN OF WHA	YES 2 NO
215-0020 standing physician. as the burial-transit	BY FUNERAL	918 Wolfe Stree 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 IF YES, GIVE WAR	YES 2 N	IED D	l h	MAS DEC		n, Mexica	n, Puerto Ric	(Specify Yes can, etc.)		SA 14. RACE — Black, W Specify: Wn:	American Indian, hite, etc.
12 12	PLETED	15. DECEDENT'S EC (Specify only highest gra Elementary/Secondary (0-12) 1 2		(Giv	e kind of t Do NOT us	usual oc work done of se retired.)	luring mo:	st of workin	-		Chur		USTRY	ospital
YLAN	E COMPL	17. FATHER'S NAME (First, Middle, Last) Frank Thomas M			1001	.01 1	Lanc	18. MOTH	IER'S NA	ME (First, Mic	th Fo	Sumame)	one m	DSPILAI
MAR retained 5 should notlifted	TO B	19a. INFORMANT'S NAME (Type/Print) Mr.T.G. Whedbee,	Jr.								um, M		Code) 1093	
ALTIMORE, Neath. Page 6 may be numeral director, page 5		20e. METHOD OF DISPOSITION 1	moval from State	20b. PLACE AI Carpetacy, crem Metro				me of		DATE			ity or Town,	
BALTIM after death. Page by the funeral direct moval. cal examiner in		21. SIGNATURE OF FUNERAL SERVICE	ICENSEE							eral l	Home Balt	imor	e MD	21231
in 24 hours aft siy filled in by action, or remo		23. PART I. Enter the disease, o shock, or heert fellure immediate CAUSE (Final disease or condition resulting in death)	C A (PDIA	2	ARI	RYT	TH M	HA				est,	Approximate interval Between Onset and Death
68 ecut and c buria	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR	AS A CONSEQUENCE OF	UENCE O	F):	CF	4RD	101	n70	PATE	17		
S, P.O. B death certificate attending physiental Hygiene print, or other t	SERTIF	that initiated events resulting in death) LAST	d	DUE TO (OR AS A CONSEQUENCE OF):										
ORDS that the d ed by the th and Mer	MEDICAL (OR D	LINER	7	150	AS I	ceuse g	jiven in		PERFOR	MED?	AM CO OF	RE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
ITAL R ITAL R V: The law re Icate has bee State Dept. o	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER		ACE OF D	EATH (Ch	eck only one)				
OF VITAL RECO PHYSICIAN: The law requires th this certificate has been signed with the State Dept. of Health riced, or Item 23 shows an	PHYSI	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	1 Inpetient 2 ER 28a. DATE OF INJ (Month, Day, V	URY	28b. TIM	4 🗌 Nurs		JRY AT	sidence	6 Other (Specify)	JURY OCC	URED	
DIVISION OF VITAL RECO DR ATTENDING PHYSICIAN: The law requires DIRECTOR: After this certificate has been sign hours after death with the State Dept. of Heal Item 28 is marked, or Item 23 shows.	TED BY	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide detarmined	28s PLACE OF IN	JURY — At hori (Specify)	ne, farm, :	M street, facto		ES 2] NO	281. LOCAT	TON (Street a Town, State)	nd Number (or Rural Rout	Number,
DIVISI SPITAL DR ATTEN VERAL DIRECTOR: Nin 72 hours after (T: 1f 16m 28 1	COMPLE		SICIAN: To the bast of my											d manner as stated,
TO THE HOSPITAL (1) TO THE FUNERAL D De filed within 72 ho IMPORTANT: If It	BE	29b. SIGNATURE AND TITLE OF CERTIF	hausen lik	2 m.r	· .			29c. LICE		18ER		29d, DATE	1-11	onth, Day, Year)
	10	30. NAME AND ADDRESS OF PERSON VA.C. CHOUVA	TUT (DEATH (ITEM	27) (Type	Print) ROA	DWI	AY		•				
		31. DATE FILED (Month, Day, Year) MAR 3 0 1993	32. REGISTRAR'S Julia Davi		dell.									

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13/57			0	2 00501								
0	STATE OF MARYLAND / DEPARTMENT OF	HEALTH AND MENT/		3 08531								
(A)	REGISTRAR CERTIFICATE OF		REG. NO.	3. TIME OF DEATH								
2 4	Sophie milzman SOPHIE MILZN	Sophie milzman SOPHIE MILZMAN 03 27 93 3 20 AM										
25	4 SOCIAL SECURITY NUMBER 6. SEX 6. AGE (in yrs. last birthday) F UNDER 1 YEAR 1	HOURS MIN. 7. DATI	nth, Day Year	BIRTHPLACE (State or Foreign Country) USSIA								
- E		OR LOCATION OF DEATH	9c. COUNT	Y OF DEATH								
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOC.	ATION	and the second	10d. INSIDE CITY								
				1 Yes 2 No								
FUNERAL	GREENSPRING & BELVEDERE AVE.	21215	10g. CITIZE	USA								
B		CENDENT OF HISPANIC ORIG pecify Cuban, Mexican, Puerto S 2 NO Specify:		8. RACE — American Indian, Black, White, etc. Specify: WHITE								
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) E. COOCCUENT	10N 16 nost of working	8b. KIND OF BUSINESS/INDU	втяу								
	17. FATHER'S NAME (First, Middle, Last) ISAAC MILZMAN	GROCERY 16. MOTHER'S NAME (First, Middle, Maiden Surmarne) PEARL KOREN										
TO BE	10s INFORMANT'S NAME (Type/Driet)											
	20e. METHOD OF DISPOSITION 1 Comparison 2 Commatton 3 Commatten 20b. PLACE AND DATE OF DISPOSITION of cemetary, crematory or other place) 4 Comparison 6 Commatten 6 Commatt		20c, LOCATION — CH	ty or Town, State E, MARYLAND								
Name of the last	SOL SOL	AND ADDRESS OF FACILITY LEVINSON & E	BROS. FUNERAI	L HOME, INC.								
	23. PART. Enter the diseases, or complications that caused the death. Do not enter the m	O RETSTERSTON node of dying, such as ce	ordiac or reapiratory erre	at, Approximate interval Batween								
	ahock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition											
, and a	disease or condition resulting in death) a.											
ATION	Sequentially list conditions, If any leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
- 1 0	if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											
CERTIF	reaulting in death) LAST											
MEDICAL (ng cause given in Part i.	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?								
T. ME	congestive heart tailure		/	1 TYES 2 NO								
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTMER:	PLACE OF DEATH (Check only	one)									
PHYSICIAN:	1 U YES 2 NO 1 I Inpetient 2 ER/Outpetient 3 DOA 4 Nursing He 27. MANNER OF DEATH 28s. DATE OF INJURY 26b. TIME OF 28c. I	ome 6 Residence 6 Ot NJURY AT 28d. D	ther (Specify) DESCRIBE HOW INJURY OCCU	JRED								
BY P	2 Accident Investigation	VORK? YES 2 NO										
	II 2 Pulate - I 208, PLACE UP INJURY - At nome, farm, street, factory, or	10e 28f. L0	OCATION (Street and Number of ity or Town, State)	r Rural Route Number,								
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, do one) 2 MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion											
E H	ROBERT T CHOW MD	29c. LICENSE NUMBER D 34 85/	29d. DATE	SIGNEO (Month, Day, Year)								
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert T Chow MD, Suite ZZ, 2435 h	s betredere	Ave Balt	MD 21215								
	31. DATE FILEO (Month. Dav. Year) MAR 32. REGISTRAR'S SIGNATURE 8 0 1993 June Davidson-Rand	4.00										



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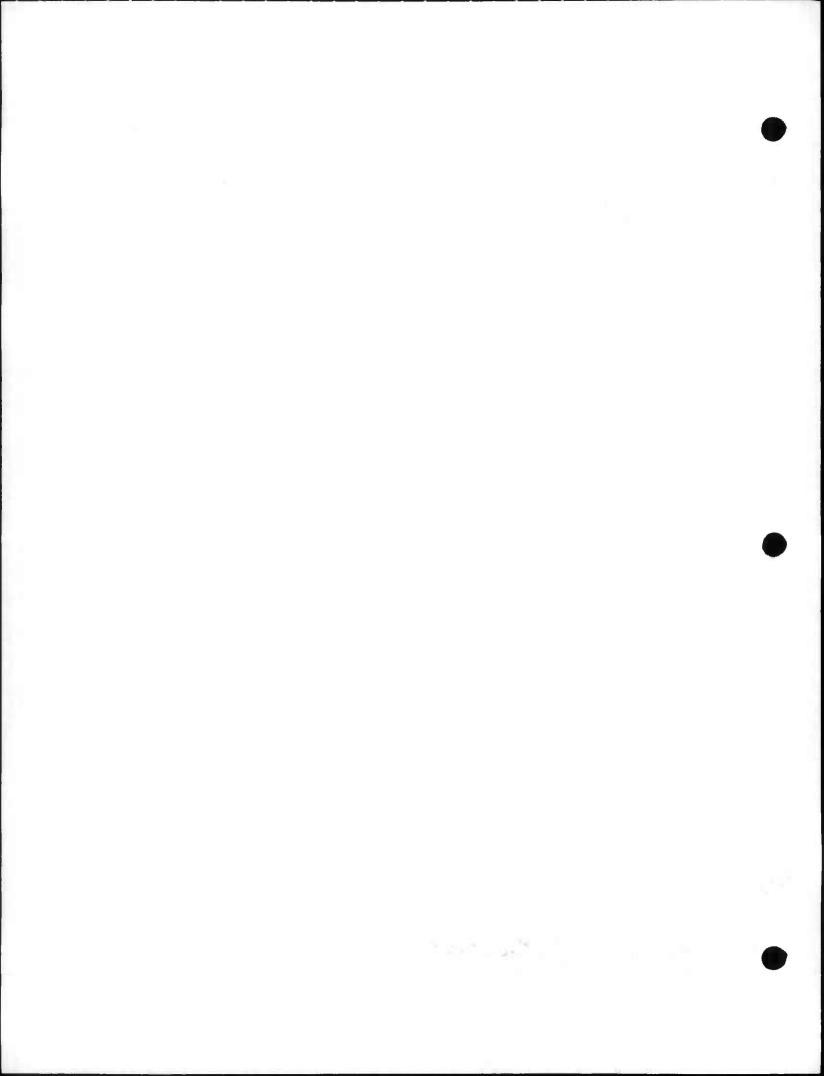
The FUNEAL DIRECTOR: After this certificate has been signed by the attending physician.

To THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

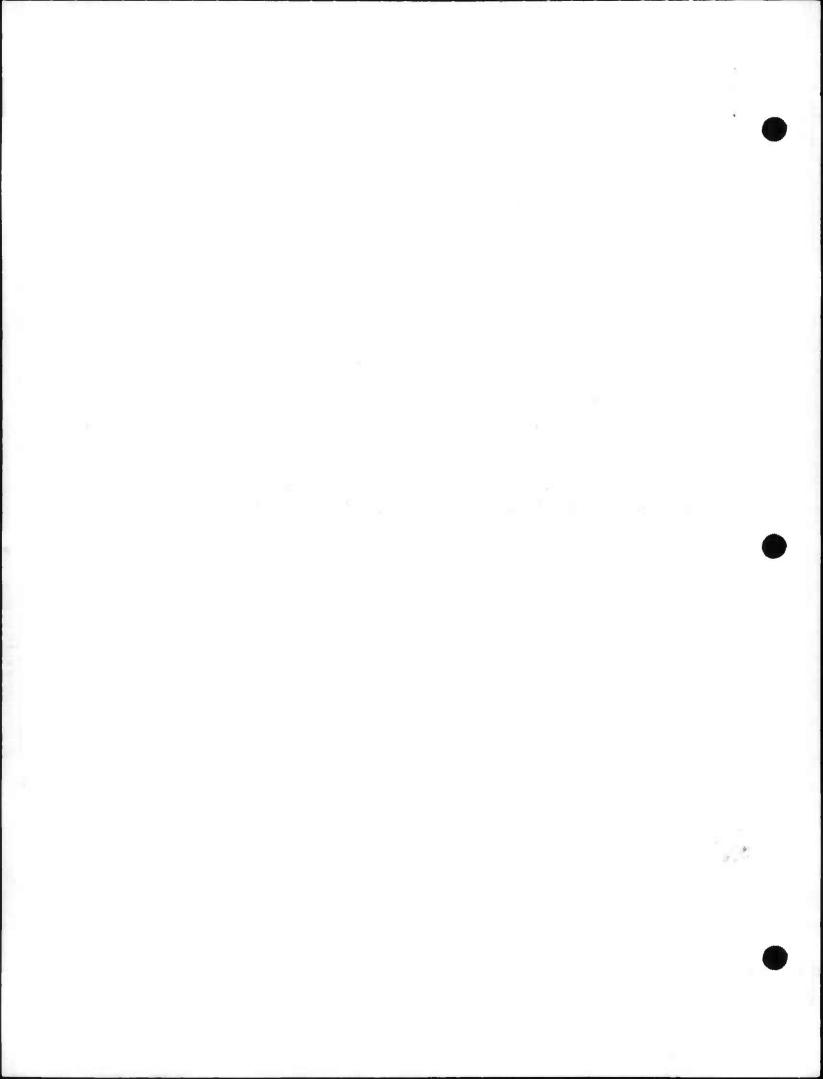
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760,

STATE OF MARYLAND / DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE	OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTM	ENT OF HI	EALTH AND I	MENTAL HYGIEN REG. NO				
16	1. DECEDENT'S NAME (First, Middle, Lest) Marjorie	Lee		Nixon		2. DATE OF DEATH MONTH March 2	5, 1995	3. TIME OF DEATH 9:02pm		
1	4. SOCIAL SECURITY NUMBER 213-30-2608	5. SEX 6. AGE (In yrs. 1 M 2 X F 58	last birthday) IF I MON	UNDER 1 YEAR THE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 7-4-1934	0. 6	BIRTHPLACE (State or Foreign Country)		
TOR B	9a. FACILITY NAME (If not institution, give str Maryland Genera RESIDENCE OF DECEDENT		9b.		timore		9c. COUNTY	OF DEATH		
DIRECTOR	10a. STATE 10b. COUNTY		100	imore	ON		_	10d. INSIDE CITY LIMITS? 1 VES 2 NO		
FUNERAL	10e. STREET AND NUMBER 4402 Fernhill A	venue		101.	ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA			
В	11. MARITAL STATUS 1 Never Married 2 XMarried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ARMED /NO	RACE — American Indian, Black, White, etc. Specify: Black						
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) 12th	ATION 16a. College (1-4 or 5+)	DECEDENT'S USU. (Give kind of work of life. Do NOT use reti	done during most		16b. KIND OF BU	SINESS/INDUST	RY		
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden e Washingt				
TO BE	19a. INFORMANT'S NAME (Type/Print) Renay Allen		196. MAILING ADD 2119 A1	ness (Street and	d Number or Rural i	Route Number, City or Tow Baltimore,	n, State, Zip Cod	216		
	20e. METHOD OF DISPOSITION 1	val from State 20b. PLAC cemetery,	CE AND DATE OF DIS Cremetory of other R	sposition (Name	emetery		cation — city allao,			
	21. SHUMATURE OF PUNERAL SERVICE LICE			22. NAME AND March	F/H Wes Wabash					
	23. PART I. Enter the disesses, or co shock, or heart failure. L IMMEDIATE CAUSE (Final	ist only one cause on each i	ine.	enter the mod	e of dying, suc	h se cerdisc or respi	iratory arrest,	Approximata interval Between Onset and Death		
	disease or condition resulting in death) Septic shock DUE TO (OR AS A CONSEDUENCE OF):									
NOI	Sequentisity list conditions, If any, leading to immediate Vestibulo-basilar infarct DUE TO (DR AS A CONSEQUENCE DF):									
CERTIFICATION	If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury that Initiated events resulting in death) LAST									
AL CEF	PART II. Other significant conditions	contributing to death but no	ot resulting in th	e underlying	cause given in	Part i. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS		
PHYSICIAN: MEDICA		Gastro-i Diabetes	ntestina	al plee	ding	PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
AN: N	25. WAS CASE REFERRED TO MEDICAL							1 1 123 2 1 110		
SICI	EXAMINER?	HOSPITAL:		HER:	5 Residence	6 Other (Specify)				
	27. MANNER OF DEATH 1 K Metural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	WOR	RY AT	28d. DESCRIBE HOW I	NJURY OCCURE	0		
тер ву	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE DF INJURY — At building, etc. (Specify)	home, ferm, street	, factory, office		261, LOCATION (Street a City or Town, State)		ural Route Number,		
COMPLETED	29a. CERTIFIER (Check only one) 1 SERTIFYING PHYSICI DESCRIPTION OF SERTI	IAN: To the best of my knowledge, : On the basis of examination and/	death occurred at for investigation, in	the ilme, date a	and place, and due	to the cause(a) and mar time, data and place, an	nner as stated,	use(a) and manner as stated.		
H	296. SIGNATURE AND TITLE OF CERTIFIER	Marke 1.			29c. LICENSE NUM	m/a	29d. DATE SIG	3/25/93		
5	30. NAME AND ADDRESS OF PERSON WHO WALTER Boche	, M.D.	TEM 27) (Type, Print C /	o Mary	land Ge	neral Hosp	ital			
ix	MAR 3 0 1993 full	Deviden Ander								



		REGISTRAR		CER	HEICAI	E OF	DEAL	<u> </u>	REG. NO	Э.		
		1. DECEDENT'S NAME (First, Middle, Last) STANLEY	NOWAKOWSI	ΚI					2. DATE OF DEATH MONTH 03 2	DAY	YEAR	:25 P. M
		4. SOCIAL SECURITY NUMBER 216-09-3172		E (In yrs. last birth	nday) IF UNDE MONTHS	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH	T		ACE (State or Foreign
3 should	1	9e. FACILITY NAME (If not institution, give s					OR LOCATIO				TY OF DEAT	
2	CTOR	617 S.BETHEL ST	REET		BAI	TIL	MORE	CIT	Y			
Pages 1.	ш	10e. STATE 10b. COUNTY	1	100	c. CITY, TOWN	OR LOCA	ATION				100	d. INSIDE CITY
£	DIR	MARYLAND			BALTI	MOF	RE				1 (YES 2 NO
nsit permit.	ERAL	100. STREET AND NUMBER 617 S. BETHEL	STREET			-10	2123				EN OF WHA	COUNTRY?
Z I Z I 3~00 Z 0 al or attending physician. for use as the burial-transit	BY FUNI	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 X YES IF YES, GIVE WAR OR	S 2 NO	13.	II yes, s	CENDENT O pecify Cubar S 2 X NO	n, Mexicen,	C ORIGIN? (Specify Y. Puerto Rican, etc.)	es or No—	Black, W Specify:	American Indian, hite, etc.
r attend use as	윤	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDE	NT'S USUAL O	CCUPAT	ION	N7	16b. KIND OF BI	JSINESS/INDU		
	IPLET	Elementary/Secondary (0-12) 12 YEARS	College (1-4 or 5+)	RET.	IOT use retired.)	during n	ost of working	ry	BEER	INDU	STRY	
by the hospital be detached for		17. FATHER'S NAME (First, Middle, Last)	LICIAT						E (First, Middle, Meide	n Surname)		
	i u	VINCENT NOWAKO 190. INFORMANT'S NAME (Type/Print)	MSKI						OWOREK			
		MR. JOHN NOWAKO	WSKI	726	S. F	s (Street	INSON	or Runal Ro	REET BAL	wn, Stete, Zip (Code) MD	21224
AL IIMORE, death. Page 6 may be funeral director, page		20e METHOD OF DISPOSITION 1 \(\times \) Burlel 2 \(\times \) Cremetion 3 \(\times \) Rem 4 \(\times \) Donation 5 \(\times \) Other (Specify) \(\times \)	oval from State C	DE PLACE AND DE PROPERTO COMPANDA DE LA CREDO	ATE OF DISPO	SITION	leme of) F ΜΔ	ARY	1	OCATION - C	,	
death. Page tuneral din		21. SIGNATURE OF FUNERAL SERVICE LE		A					UNERAL			110.
~ - 2 78	1	(Mummal	Samuel						T. MARYL		2122	4
outhin 24 hour completely filled is compation. or event, the man		23. PART I. Inter the diseases, or chock, or heart fellurs. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	BUE TO (OR AS	A CONSEQUEN	CAOD!							Intarval Between Onset and Dsath
certificate be execut ding physician and of tygiene prior to bunit	ERTIFICATION	oue to (or as a consequence of): If any, Isading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST										
5 5 5	CER	resulting in death) LAST										
# # E	AL (PART II. Other algnificant condition	s contributing to death	but not rasult	ting in the u	nderlylr	ng cause g	ivan in P	art I. 24a. WAS A	N AUTOPSY		RE AUTOPSY FINDINGS
res the signed leafth leafth	AEDICAL					_			_ 1 to res		COI OF	MPLETION OF CAUSE DEATH? YES 2 NO
has been s Dept. of H	N: M											
N: The law icate has State Dept		25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHE	R:	LACE OF OE					
SICIAN: The Certificate the State	HYS	1 X YES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 ER/Ou 28e. OATE OF INJURY		OA 4 Nu		JURY AT		Other (Specify)	IN HIRY OCCI	IREO	
After this death with	ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)		INJURY M	1 🗌	YES 2		- DEVOTIGE NOT			
TEMPORE PHYSICIAN: The law requirement of the transfer this certificate has been set that death with the State Dept. of the sampled, or item 23 show	ETED	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJUR building, etc. (Sp	IY — At home, fe ecify)	erm, street, fac	tory, offi	CB	:	281. LOCATION (Street City or Town, State	end Number o	or Rural Route	Number,
(M	COMPLE		CIAN: To the best of my kno									d menner ee stated.
TO THE E	BE	SOUTH OF CERTIFIER	le					. M . E			SIGNEO (MO	nth, Day, Year) 93
		PARAMOD A.	OREU MO			St	reet	, Ba	ltimore	, Mar	rylan	d 21201
14)		MAR 2 0 1993	32. REGISTRAR'S SIG								-	_
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FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN Palensky tella YEAR E O 07:53 AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SE 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign Country) 0 84 YRS. DAYS HOURS -40 1 1 M 2 1821 Czechoslovakia Pages 1, 2, 3 should 9e, FACILITY NAME (If not institution, give street end number Baltimore CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Herbor Hospital C DIRECTOR 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Baltimore 1 YES 2X NO by the funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3 - 15th Avenue 21225 U.S.A. retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 1 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. II yee, specify Cuben, Mexican, Puerto Ri 1 YES 2 NO Specify: 1 Never Merried 2 Merried BY IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION becify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (So Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Home Maker once. 17, FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surneme) Stengl Steng1 Anna BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Estelle Racioppa 305 Zang Street Apt. 3044 Lakewood, Col. 80228 24 hours after death. Page 6 may be pe 20e. METHOD OF DISPOSITION

1 Description | Method | Description | Descr 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE must Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3/31 Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
George J. Gonce Funeral Home P.A. Lerome namusurs 4001 Ritchie Hwy. Baltimore, Md. medical filled in by t' 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory errest, Approximate shock, or heert fellure. Liet only one ceuse on each line. Interval Between 0 **IMMEDIATE CAUSE (Final** Onset and Death attending physician and completely fille mal Hygiene prior to burial, cremation, the state of disease or condition SEPTIC SMOCIC within 3 resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): executed LIDSEPSIS traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate occlusion Orteno cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST 0 requires that the death has been signed by the atter Dept. of Health and Mental PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO эпу COMPLETION OF CAUSE 1 | YES 2 | NO OF GEATH? Shows 1 YES 2 NO PHYSICIAN: PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) tem this certificate State HOSPITAL:
1 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO 4 ☐ Nursing Home 5 ☐ Rasidence 8 ☐ Other (Specify) 0 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. OESCRIBE HOW INJURY OCCURED marked, WITH 1 Natural RECTOR: After th ours after death w. 1 YES 2 NO BY 2 Accident ATTENDING 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner ee stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end piece, and due to the cause(a) and menner as stated. BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Harbor Hosp. (Enter 3 28 93 OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9 3001 S. Harrover Baltimore 51. Haibir 32. REGISTRAR'S SIGNATURE

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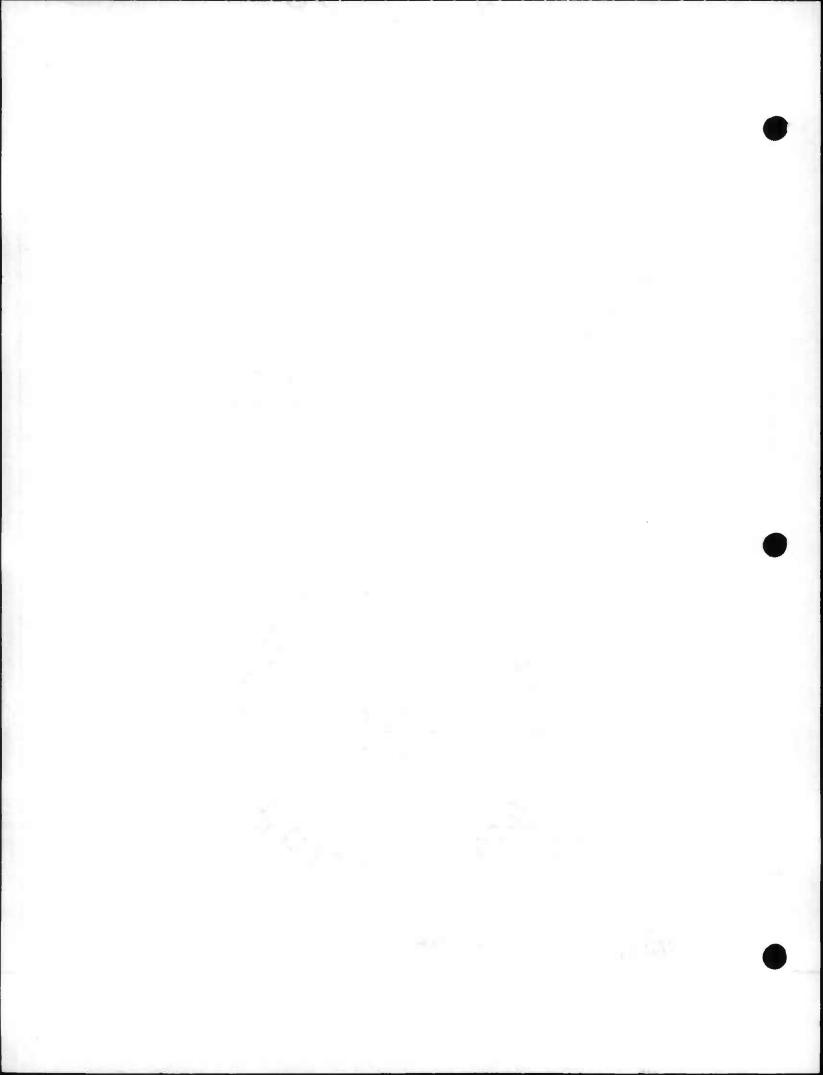
ICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician,	cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
WITH OR ATTENDING PHYSICIAN: The law requires that	HTML DIRECTOR: After this certificate has been signed by 2 hours after death with the State Dept. of Health an	ff. If item 28 is marked, or item 23 shows any	

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	MENT OF HEALTH A	ND MEN	ITAL HYGIENE REG. NO.	20	00333	
- 6	1. DECEDENT'S NAME (First, Middle, Last)					DATE OF DEATH		3. TIME OF DEATN	
	EDNA		TO	TER		юнтн дау ЭЗ 28	93	01:10 PM M	
i i	4. SOCIAL SECURITY NUMBER 212-05-8696	5. SEX 6. AGE		UNDER 1 YEAR IF UNDER 24	HRS. 7. D	ATE OF BIRTH	8. BIR	THPLACE (State or Foreign nitry)	
	9e. FACILITY NAME (If not institution, give	9c. COUNTY OF	The state of the s						
DIRECTOR	NORTH ARUNDEL H	OSPITAL ASSO	CIATION	GLEN BURNI	E		. COUNTY		
E	10a. STATE 10b. COUN			OWN OR LOCATION			· · · · · ·	10d. INSIDE CITY LIMITS?	
	Md. Ba	ltimore	Arbu					1 TYES 2 NO	
FUNERAL	942 Palladi Driv	re ·		101. ZIP CODE 21227	,		10g. CITIZEN OF WHAT COUNTRY?		
Š	11. MARITAL STATUS	12 WAS DECEDENT EVED I	N U.S. ARMED	13. WAS DECENDENT OF N		RIGIN? (Specify Yes o		CE — American Indian,	
B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO	If yee, specify Cuban, &			Bia	ick, White, atc.	
	15. DECEDENT'S EDI (Specify only highest grad	JCATION le completed)	16a. DECEDENT'S US	done during most of working	T	16b. KIND OF BUSIN	NESS/INDUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re	tired.)					
١١	17. FATHER'S NAME (First, Middle, Last)		Straw E	at Maker					
	August Otter				S NAME (FI	irst, Middle, Maiden Su	umame)		
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street and Number or		Number City or Town	State Zin Code)		
임	Dorothy H. Mich	ael		ayside Drive				19	
	20a. METNOD OF DISPOSITION 1 Buriel 2 Cremation 3 Rer 4 Donation 5 Other (Specify)	noval from State 20b	PLACE AND DATE OF D netery, crematory or other	isposition (Name of place) Cemetery	3/	/	timore		
	21. SIGNATURE OF FUNERAL SERVICE L		Doddon Tax	22. NAME AND ADDRESS (OF FACILITY	/		120.1	
	· Lary	L. Kaul	meny	Gary L. Kau 5695 Main S	tree	t. Elkrid	ge. Md.	21227	
ERTIFICATION	23. PART I. Enter the diseases or complications that caused the deeth. Do not enter the mode of dying, such ea cerdiec or respiratory erreet, shock, or heart failure. List only one cause on each light interval Between Onset and Death disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
E C	PART II. Other significent condition	ns contributing to deeth b	eut not resulting in t	he underlying ceuse give	n in Part	I. 24a. WAS AN AL	JTOPSY 24	b. WERE AUTOPSY FINDINGS	
MEDIC						PERFORM		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF CEATH?	
ÿ									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PLACE OF OEAT					
₽	1 TYES 2 NO 27. MANNER OF OEATH	1 Inpetient 2 ☐ ER/Outp	28b. TIME O	Nursing Home 5 Reside		Other (Specify) OEŞCRIBE HOW INJ	UEV OCCUPEO		
E F	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	M 1 YES 2 N		OESCHIBE HOW INJ	UNY OCCURED		
ED	3 Suicide 6 Could not be determined	building, atc. (Spec	— At home, term, atree	t, factory, offica	28f.	LOCATION (Street and City or Town, State)	1 Number or Rural	Route Number,	
COMPLEIED		SICIAN: To the best of my know ER: On the basis of axamination						(s) and manner as stated.	
	296. SIGNATURE AND TITLE OF CERTIFIE	B. M. E	}	29c. LICENS	NUMBER	2-8	DATE SIGNE	O (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WE ELMO M. GAYOSO.	M.D./273-F			מ זטא	MADVIAN	D 21012		
	DA DATE EN STO AL TO DO ALL	32. PEGISTRAR'S SIGN		LART ROAD/ AR	иоци,	PIAKILAN	D 41012		
	MAR 3 6 1993	1 a variason of	- Common - C				<u> </u>		

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

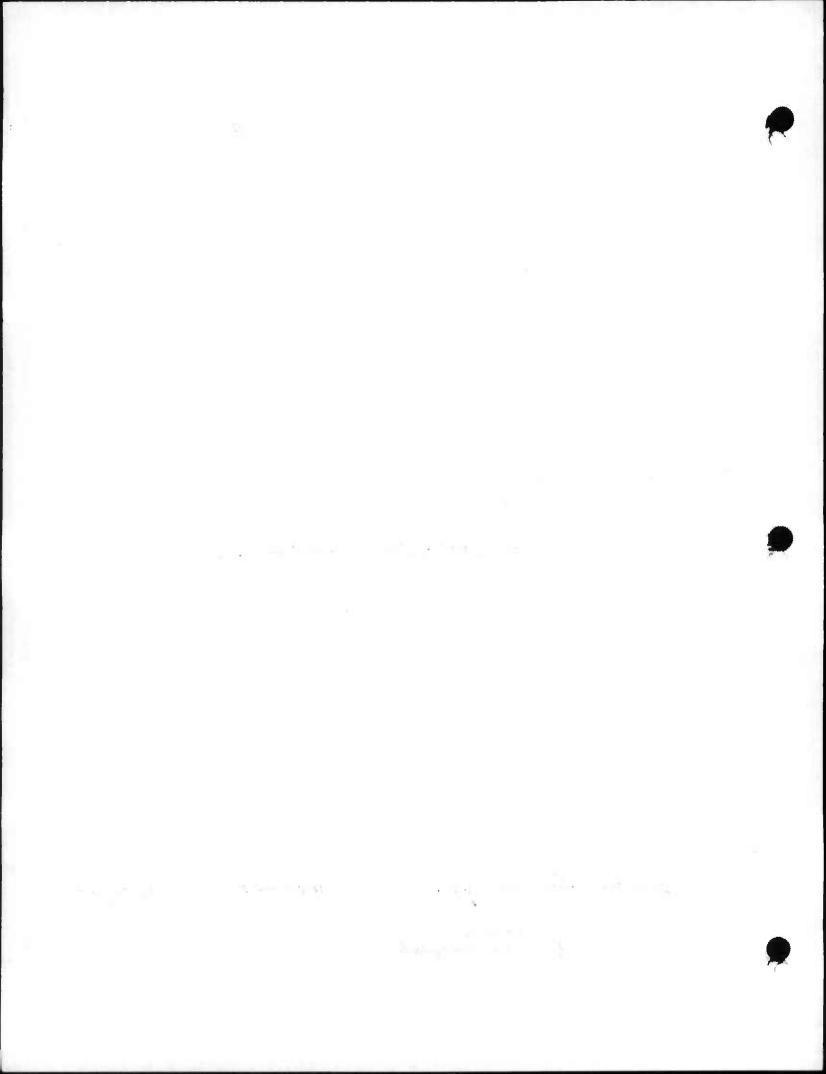
			·						, , ,		HEG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) Robert					OWENS				2. DATE OF DEATH DAY MAYCh 29 1:			YEAR	S. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER		5. SEX 6. AGE (In yrs. las		last birthday)				24 HRS.	7. DATE OF	DATE OF BIRTH (Month, Day, Year)		8. BIPTHPLACE (State or Fi		I
5	217-38-5412		1 ₂ M 2 F	5.	1. YRS.	MONTHS	S DAYS	HOURS	MIN.		18,19	941		h Carolina	
3	9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital					9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH					
DIRECTOR				Rossville Baltimore											
<u> </u>	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY				10c. CITY, TOWN OR LOCATION							T	IOd. INSIDE CITY		
	Md.							Baltimore						LIMITS?	
	10e. STREET AND NUMBER					10f. ZIP CODE					10g. CITIZEN OF WHAT				
EB	1032 Quantril Way					21205					USA				
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT				EVER IN U.S. ARMED YES 2 NO			13. WAS DECENDENT OF HISPANIC (If yes, specify Cuban, Mexican, P				or No—	14. RACE	- American Indian, White, etc.	I
BY	1 Never Married 2 2 3 Widowed 4 Div	IF YES, GIVE Y					Specify		Puerto ricert, etc.)		Specify: White				
		CATION completed)	DECEDENT'S USUAL OCCUPATIO					16b. K	16b. KIND OF BUSINESS/INDU				ĺ		
COMPLETED	Elementacy/Secondary (0-12)		College (1-4 or 5+)		Custodian		1.)	f most or working		P	PerryHallSr		.HighSchool		
NO.	17. FATHER'S NAME (First, A		18. MOTHER'S NAME (F				ME (First, Mid	(First, Middle, Melden Surname)							
6	Robert Frank Owens							Mary Elizabeth Hipps							
2											^{Code)} 2 0 5				
	1 Burial 2 Cremation 3 Removal from State cemetery, cr					ATEOFDISPOSITION (Name of or other place) Hill Cemetery 4/1/93 Baltimore MD									
	21. SIGNATURE OF FUNERA	22. NAME AND ADDRESS OF FACILITY													
	Connelly Fundal Home ConnellyFuneralHome 300MaceAve. 21221														
N	23: PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Right Cerebral Vascular accident DUE TO (OR AS A CONSEQUENCE OF):														
TIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that lettled excess.)														
CERTIFI	that initiated events resulting in death) LAS	TON AS A COM													
	PART ii. Other significant conditions contributing to death				out not resulting in the underlying			ng cause :	ig cause given in Part		le. WAS AN			VERE AUTOPSY FINDINGS	
IN: MEDICAL CI	Cardiomyopathy										PERFORMED? 1 ☐ YES 2 💢 NO		6	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
SICIAN: N	25. WAS CASE REFERRED TEXAMINER? 1 YES 2 NO	TO MEDICAL	HOSPITAL:		L. EL-W.	ОТН	ER:			eck only one)					
Ξ	27. MANNER OF DEATH		1 CXInpatient 2		3 L DOA		1	IJURY AT	reldence	6 Other (S		LIURY OCC	URED		
ВУ Р	1 Netural 5 Pending (Month, Dey, Year) 2 Accident Investigation 3 Suicide 6 Could not be determined (Month, Dey, Year) 28e. PLACE OF INJURY — At hor building, etc. (Specify)					INJURY WORK? M 1 VES 2) NO						
ETED						e, farm, street, factory, offica				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
	29a. CERTIFIER (Check only one) 1 CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: Dn the basis of sxamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.														
O BE COMP	296. SIGNATURE AND TITLE ROYALD		29c. LICENSE NUMBER			IBER	29d. DATE SIGNED (Morith, Day, Year) 3/29/93								
¥	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1012 Old North Point Rd., Baltimore Maryland 21224														
	31. DATE FILED (MORTH, Day, Year) MAR 3 0 1993 Guid Davidson-Maria Strange Company Co														



BALTIMORE, MARYLAND 21215-0020

	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last) MARY	O'CONNOR				2. DATE O	OF DEATH	' ₂	3. TIME	OF DEATH		
	4. SOCIAL SECURITY NUMBER		In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE 0				6:30PM		
		1 🗆 M 2 💢 F	68 YRS.	MONTHS DAYS	HOURS MIN.	_(Month,	Day Year) -24	١	COUNTY) MARYLA	AND		
	9a. FACILITY NAME (If not institution, give s	treet and number)		96. CITY, TOWN	OR LOCATION OF D	EATH		9c. COUNTY				
DIRECTOR	11 S. LINWOOD AVENUE BALTIMORE											
EC	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSI									SIDE CITY		
	MARYLAND		В	ALTIMOF	RE		LIMITS? 1 YES 2 NO					
FUNERAL	100. STREET AND NUMBER		10	I. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?					
JNE	11 S. LINWOOD A	12. WAS DECEDENT EVER IF	I U.S. ARMED	13 WAS DEC	21224 ENDENT OF HISPA	NIC OBIGINS	/Caseth, Van	USA	RACE — Ame	dana te dian		
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes, sp	ecify Cuban, Maxico	an, Puerto Ri		or 140— 14.	Black, White, Specify:	etc.		
D BY	3 🔀 Widowed 4 🗌 Divorced	1000							WHITE			
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade	completed)	16a. DECEDENT'S (Give kind of life. Do NOT u.	WORL OCCUPATION Work done during money me retired.)	ON ast of working	16b.	KIND OF BUS	INESS/INDUS1	TRY			
<u>P</u>	Elementary/Secondary (0-12) 6 YEARS	College (1-4 or 5+)	HOMEM	11121								
NO.	17. FATHER'S NAME (First, Middle, Lest)) · · · · · · · · · · · · · · · · · · ·	HOHEM	MINEN	18. MOTHER'S NA	AME (First, M	iddle, Maiden S	Sumame)				
BE C	PETER WDZIECZY	YN			ROSE N	OVAK						
TO B	19a. INFORMANT'S NAME (Type/Print)	11100			and Number or Rural	Route Numbe	or, City or Town	, State, Zip Coo	de)	-		
MS. JOYCE O'CONNOR SAME 20e, METHOD OF DISPOSITION 1 X Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SALTO CO												
	21. SIGNATURE OF PUNERAL SERVICE LIC	ENBEE	7.		ROWSKI							
_	C. Saymona	Desarone	sec		FLEET !					4		
	21. PART I. Enter the diseases, or a shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. META	STAT	CL				atory arrest	In	pproximate terval Between nset and Death		
_	DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditione, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
FIC	CAUSE (Disease or Injury	DUE TO (OR AS A	CONSEQUENCE O	Pi:								
E	that initiated events resulting in deeth) LAST	4		,					į			
	PART II Other elepiticent condition	e contribution to don't b				- I						
JICAL	PART II. Other algoriticent condition	e contributing to death b	ut not resulting	in the underlyin	g ceuse given in		24a. WAS AN A PERFORI 1 YES 2	WED?	COMPLE	UTOPSY FINDINGS LE PRIOR TO TION OF CAUSE		
PHYSICIAN: MEDIC									OF OEAT	S 2 NO		
ż												
호	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PI	ACE OF DEATH (Ch	neck only one,)					
17S	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outp		4 - Nursing Hom	e 5 Realdenca							
	1 Netural 5 Pending	(Month, Day, Year)	28b. TIM	URY WO	INTERPRETATION OF THE PROPERTY	28d. DESC	RIBE HOW IN	JURY OCCUR	ED			
) BY	2 Accident Investigation 3 Suicide 6 Could not be	28s. PLACE OF INJURY	— At home, farm,					nd Number or F	Rural Floute Nun	nber,		
	4 Homicide datarmined	building, atc. (Spec	ny)			City or	Town, State)					
COMPLETED		CIAN: To the best of my knowl R: On the besis of examination							use(a) and me	nner as stated.		
	29b. SIGNATURE AND DITLE OF CERTIFIER	0			29c. LICENSE NUI	MBER		29d. DATE SI	GNEO (Month, I	Day, Year)		
TO BE	sure &		6.		H432	34		· 3/	24/8	3		
	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETEO CAUSE OF OE	ATH (ITEM 27) (Type	, Print)				-	-			
	31 DATE FILED (Month, Day, Year)	37 APOIGURAD'S BION	NEURE									
1	MAR 3 0 1993	Freis Daviden	Rubell									

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page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

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DIVISION OF VITAL RECORDS, P.O. BÓX 68760	9	9 6
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	LEJ	III TO
	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	7 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremati
	0	-

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH oSTE DECEDENT'S NAME (First, Middle, Last) e Rice Arna Oster 2. DATE OF DEATH MONTH 3. TIME OF DEATH 28 0300 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Morith, Day, Year) 5-30 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 69-09-2726 98 DAYS HOURS 1 M 2 F YRS Kentucky 30 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ANNAPOLIS AACo ANNE ARUNDEL ME MEDICAL CENTER 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD AACo ANNAPOLIS 1 KWES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 130 Hearne Rd # 411 21401 USA 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, stc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 2 200 If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 TES 2 NO 3 Widowed 4 Divorced Specify: ВҮ White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16h KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Sales Shirt manufacturer 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at JOHN ELLIOTT RICE ELIZABETH JANE DANIEL 8 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 2 NORMA R. CARPENTER Tanglewood Lane, Davidsonville, Md. 21035 9 20e. METHOD OF DISPOSITION
1 □ Burial XX Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must □ Donation 5 □ Other (Specify) Metro Crematory Baltimore.Md. examiner 21. SIGNATURE JOF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 12 RIDGLEY AVE; ANNAPOLIS, MD. 21401 LAMBO HARDESTY FUNERAL HOME. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reepiratory strest, Approximate shock, or heart failure. List only one cause on each line. interval Betw **Onset and Death IMMEDIATE CAUSE (Fine)** the disesse or condition resulting in death) or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS any 17BRILLITE 1 TYES 2 THO Shows a 1 TYES 2 THO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem HOSPITAL: OTHER: 1 YES 2 NO ent 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 6 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO 87 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide .22 6 Could not be COMPLETED 4 Homicide 28 Item 1 SERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. TO THE FUNERAL I be filed within 72 h IMPORTANT: If I (Check only one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner ee stated. 29b. SIGNATURE AND THE OF CERT 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 300 9 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)

1993

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32. REGISTRAR'S SIGNATURE ha Davidson

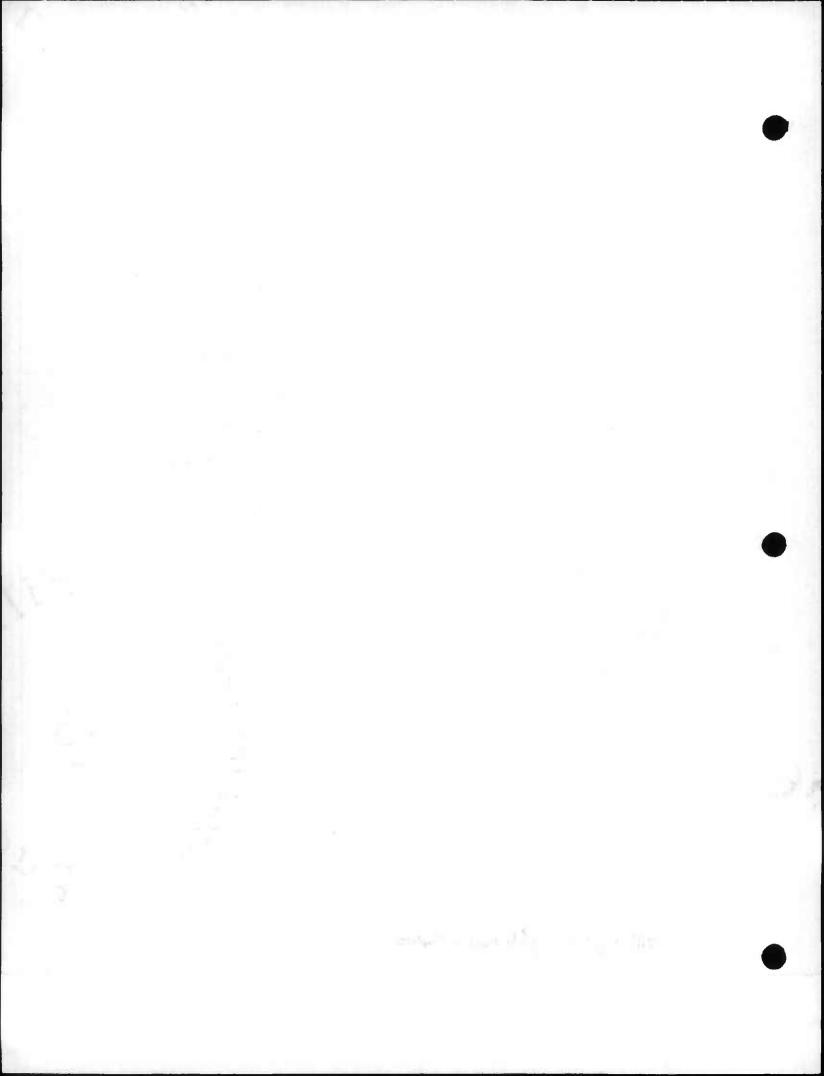
BALTIMORE, MARYLAND 21215-0020

1 - FOR STATE REGISTRAR

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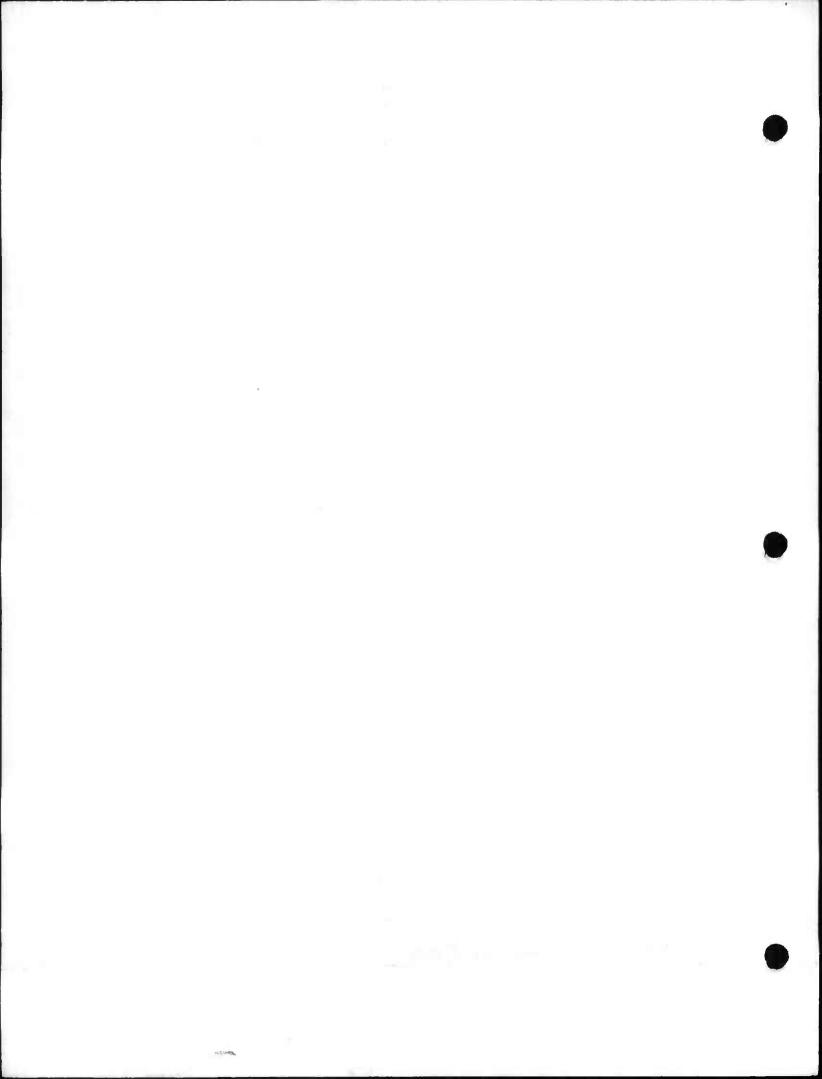
	1. DECEDENT'S NAME (Float		Herson	LIA	M AL	LEN	PATT	ERS	ON		2. DATE	OF DEATH	AY	YEAR 9 3	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 269-09-	-7925	1 M 2 - F	6. AGE	(In yrs. last	birthday) YRS.	IF UNDER	DAYS		R 24 HRS.	7. DATE (Month)	Day, Year)	Ţ.	Count	HPLACE (State or Foreign ry) York
СТОВ	ST. JOSEN	oh t	treet and number)				9b. CITY	, TOWI	Tow					Bal-	FIMOR C
DIRE	Maryland	10b. COUNTY	imore				v, rown o uthe:								10d. INSIDE CITY LIMITS? 1 YES 2 NO
ERAL	400 Fox Cha	apel Di	r.					- 11	21093		·			S.A.	WHAT COUNTRY?
BY FUNE	11. MARITAL STATUS 1 Never Married 2 3 Wildowed 4 Divo		12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WI	YES	2 🔀 N	! ☑NO If yes, specify Cuben, Mexican, Pr						CORIGIN? (Specify Yes or No— Puerto Rican, etc.) 14. RACE Black Specific S			E — American Indian, k, White, etc.
PLETED		(Specify only highest grade completed)			(Gi life.	ve kind of	se retired.)		TION most of work	ing		ngine		DUSTRY	
COMPL	17. FATHER'S NAME (First, M										ME (First, A	iddle, Maiden	Sumame)		7
O BE	Frank Allen Patterson 190. INFORMANT'S NAME (Type/Print)								et and Numb		Route Numb	er, City or Tow	n, State, Z		
	Alicia P. F		oval from State	20t	. PLACEA	ND DATE	OF DISPOS	ITION	(Name of	Blyd	DATE	20c. LO	CATION -	City or To	
	1-25 Burlal 2 Cremation 3 Removal from State Completely cremptory or other place Bee Tree Cemetery 3-29 Parkton, Md.										4				
	Approximate interview diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or as a consequence of):														
ERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): oue TO (OR AS A CONSEQUENCE OF):														
MEDICAL C	PART II. Other algnificent conditions contributing to death but not result						In the Ur	nderly	ing ceuse	given in	Part I.	24a. WAS AN PERFOI 1 YES	RMED?	246	D. WERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
YSICIAN	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO	O MEDICAL	HOSPITAL:	EB/Out	netlant 2	□ DO4	OTHE	₹:	PLACE OF						
BY PHY	27. MANNER OF DEATH 1 Netural 5	Pending Investigation	26e. DATE OF I (Month, Da	NJURY		28b. TIN	_	28c. I	INJURY AT WORK?			CRIBE HOW	NJURY OC	CUREO	
ETED 8	3 Suicide 6	Could not be determined	28e. PLACE OF building, a	INJURY rtc. (Spec	f — At hor	ne, ferm,	street, fac	tory, of	ffice		281. LOCA City o	TION (Street r Town, State)	and Numbe	r or Rural i	Route Number,
MPL			CIAN: To the best of r												e) and menner as stated.
O BE CO	29b. SIGNATURE AND TITLE	n	na	han			y-n	20	29c. LK	ENSE NUI				E SIGNED	25-93
	30. NAME AND ADDRESS OF PROPERTY OF THE PROPER	TOO?	COMPLETED CAUSE T- K-H	OF OF	ATH (ITEN	27) (Type 5 T-	Print)	61	PH	HO	8/177	71_			

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



	TO BE COMBIFTED BY BUYOLOIAN, MEDICAL OFFICE CATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
funeral director, page 5 should be detached for use as the al.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.
r death. Page 6 may be retained by the hospital or attending	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.										
-	1. DECEDENT'S NAME (First, Middle, Last)	See Table		·		2. DATE OF DEATH		3. TIME OF DEATH			
	JAMES	M. PAR	HAI	7		-		3 5-10PM			
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs.	last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign			
	9a. FACILITY NAME (If not institution, give s	x□ M 2 □ F 69	YRS.	MONTHS DAYS	OR LOCATION OF D	2-11-24	9c. COUNTY	BIRTHPLACE (State or Foreign Country) A			
OR	CHURCH HOSPITA				ORE CI		JE. 000HT	OF DEATH			
딜	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	Y	10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY			
DIRECTOR	MD	·		altimor	11.5			1 (X) YES 2 NO			
₹ S	10e. STREET AND NUMBER		DI. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?								
FUNERAL	4608 Belair R				21206		SA				
	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER IN U.S., FORCES? 1 YES 2 FIF YES, GIVE WAR OR DATES	ARMED NO	If yee, sp	ENDENT OF NISPA ecify Cuben, Mexico 2 (X) NO Specia	NIC ORIGIN? (Specify Venn, Puerto Rican, atc.)	- 10	RACE — American Indian, Black, White, etc.			
ЭВУ	3 Widowed 4 Divorced			1	Z W NO Specia	71		Specify: Black			
臣	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 18. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname)										
PE	Elementary/Secondary (0-12)	College (1-4 or 5+)	me. Do NOT U	se retired.)		A1116	d Che	mical			
N N	17. FATHER'S NAME (First, Middle, Last)				de MOZNENIO AN			IIIICai			
	Julius Parham	1			Lenora	AME (First, Middle, Maiden	Surname)				
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street)		Route Number, City or Tow	n State Zin Cor	(a)			
임	Lorraine Parha					Baltimore					
	20a. METHOD OF DISPOSITION 1 Duriel 2 Cremation 3 Ram			OF DISPOSITION (No	t Va Ce	DATE 20c. LO	ngs M	or Town, State			
	4 Donation 5 Other (Specify)		1 1 3 0 1				nys m	וווס, ויוט			
and the state of t											
H	23. PART I. Enter the diseases pro-	complications that caused the	death Do					NORTH AVE.			
	23. PART I. Enter tha diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Congestive Candoc Jadure										
	IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
S	ceuse. Enter UNDERLYING CAUSE (Disease or injury	Seps	u								
발	that initiated events resulting in death) LAST	DUE TO (OR AS A CONS	EOUENCE O	F):							
胃胃		d									
4	PART II. Other significant condition	(1)		A	g cause given in	Part I. 24a, WAS AN		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO			
MEDIC	Signo	deolor 1	10 Cm	Mus		1 _ YES 2		COMPLETION OF CAUSE OF DEATH?			
								1 - YES 2 - NO			
ä											
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PI	ACE OF DEATH (Ch	eck only one)					
ξ	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outpatient 28e. DATE OF INJURY	3 DOA 28b. TIM			8 Other (Specify)					
	1 Netural 5 Pending	(Month, Day, Year)		URY WO	PRK?	28d. DEŞCRIBE HOW I	NJURY OCCURE	ED			
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY At	home, ferm, s			281. LOCATION (Street	and Number or B	lucal Route Number			
ETED	4 Nomicide determined	building, etc. (Specify)				City or Town, State)		,			
片	29a. CERTIFIER (Check only	CIAN: To the best of my knowledge,	death occurr	ed at the time date	and place, and due	to the cause(s) and ma					
COMPL		R: On the basis of examination and/o						use(s) and menner se stated.			
Ü	29b. SIGNATURE AND TITLE OF CERDIFIE				29c. LICENSE NUI			GNED (Month, Day, Year)			
10 B(Grabally.	MD					▶3/	25/93			
F	30. NAME AND ADDRESS OF BERSON WH	O COMPLETED CAUSE OF DEATH (IT			ALT X	10212	31	/ (-			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE Julia Davidson-And		1) 0	//	IN OCIL	21				
	MAR 3 0 1993	Julia veridoon-gond	e Sile								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR	CERTIFIC	ATE OF DEATH	REG. NO.							
	1.16	ENTO .	.(-0)	2. DATE OF DEATH MONTH DAY	GEAR 3. TIME OF DEATH SOME OF DEATH						
1	4. SOCIAL SECURITY NUMBER 5. SEX M 2 F 9a. FACILITY NAME (If got institution, give street and number)		UNDER 1 YEAR F UNDER 24 HRS. NTHS DAYS HOURS MIN.	7. DATE OF BIRTH (North, Day, Yell 148	8. BIRTHPLACE (State or Foreign Country) MARYLAND						
DIRECTOR	MESIDENCE OF DECEDENT STREET DAUGINORE										
REC	10s. STATE 10b. COUNTY	10c. CITY, Tr	OWN OR LOCATION		10d. INSIDE CITY						
12.00	1947 YANYA 1945 STREET AND NUMBER		DalfineRE		1MITS? YES 2 □ NO						
FUNERAL	122 Edgewood Stx	reef	101. ZIP CODE	29	CITIZEN OF WHAT COUNTRY?						
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT E FORCES? 1 FORCES? 1 FYES, GIVE WAR	YES 2 TNO	13. WAS DECENDENT OF HISPA If yes, specify Cuben, Maxic 1 YES 2 NO Speci		o— 14. RACE — American Indian, Black, White-sec. Specify						
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USU	JAL OCCUPATION done during most of working	16b. KIND OF BUSINES	S/INDUSTRY						
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+) 4 years	Inte. Do NO! use ret	UNSELOR	DITE MEND	ALLY RETARDED						
OM	17. FATHER'S NAME (First, Middle, Last)	1 00		AME (First, Middle, Maiden Surna							
BE C	JOSEPH PIMENTO			THA BARNES	mej						
5	19e. INFORMANT'S NAME (Type/Print)		DRESS (Street and Number or Aural								
	WANDA L. PIMENTO 200 METHOD OF DISPOSITION		N. EDGEWOOD ST								
	1 Buriel 2 Cremelion 3 Removal from State 4 Donation 5 Other (Specify)	cemetery, cremetory or other parties of the ARBUTUS MEMO	placel	26/93 ARBUTI	IN City or Town, State						
	21. SIGNATURE OF GENERAL SERVICE LICENSIN	V	22. NAME AND ADDRESS OF FA	ACILITY							
	Jan 13. C	igh	2654 MARYLAN	D AVE. BALTO	NERAL SERVICE , MD. 21218						
	23. PART I. Enter the diseases, or complications that ca shock, or heart failure. List only one cause	used the deeth. Do not e	enter the mode of dying, suc	ch ea cardlec or respirator	y arrest, Approximata Interval Between						
	IMMEDIATE CAUSE (Finel disease or condition	26 0 2000	- 60		Onset and Death						
	resulting in death) a. DUE TO (OR	AS A CONSEQUENCE OF):	1 20 %	reve	lac.						
NO.	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury CHET) (OR AS A CONSEQUENCE OF):										
	that initiated events reaulting in death) LAST	AS A CONSEDUENCE OF):		1							
CEL	d. (0.	(introductions doug about you									
CAL	PART II. Other significant conditions contributing to dea	ith but not resulting in th	ne underlying cause given in	Part I. 24s. WAS AN AUTOI PERFORMED?							
ā				1 YES 2 NO	COMPLETION OF CAUSE						
PHYSICIAN: ME				_	1 TES 2 THO						
N S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (C)	eck only one)							
XSI	1 YES 2 NO HOSPITAL:		HER: Nursing Home 5 Residence	6 Other (Specify)							
	27. MANNER OF DEATH 1 Netural 5 Pending 28e. DATE OF INJ (Month, Day, Y	URY 28b. TIME OF INJURY	WORK?	28d. DESCRIBE HOW INJURY	OCCURED						
à l	2 Accident Investigation 3 Suicide 8 Could not be 28s. PLACE OF IN building, etc.	JURY — Al home, farm, atreal	M 1 YES 2 NO	28f. LOCATION (Street and Nur	imber or Rural Route Number,						
COMPLETED	4 Homicide determined	(Зраску)		City or Town, State)							
29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the Ilme, date and place, and due to the cause(s) end manner as stated.											
8	2 MEDICAL EXAMINER: On the besia of exami	nation and/or investigation, in	my opinion, death occured at the	lime, data and place, and due	to the cause(s) and manner as stated.						
BE	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUI		DATE SIGNED (Month, Day, Year)						
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE O	F DEATH (ITEM 27) (Type Print	1023	2/6	3 26 93						
	A. MIRANDA,			PAUL ST.	21202						
	31. DATE FILED (Month, Day, Year)	Sak Har		1,0	0.00						
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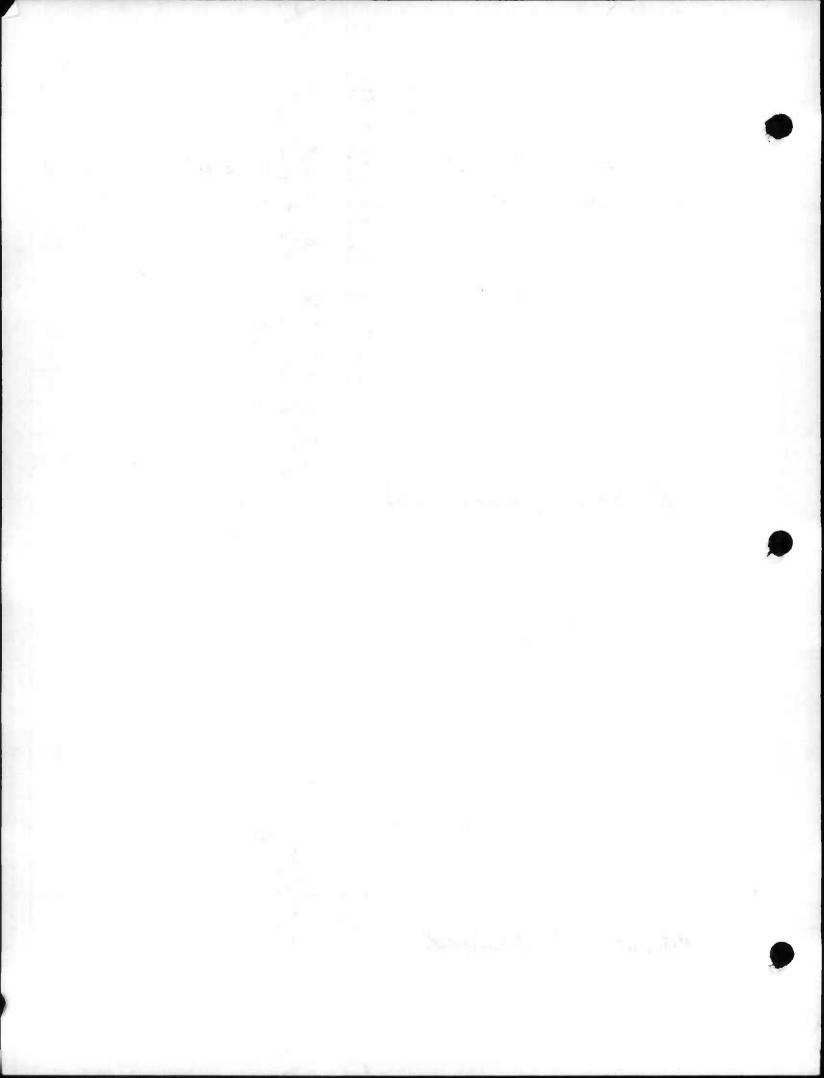
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DING PHYSICIAN: The law requires that the death certificate be executed within a clour after death. Page 6 may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	and the method of them 20 about patents of other bounds arent the medical available to soften at one
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BALTIMOFE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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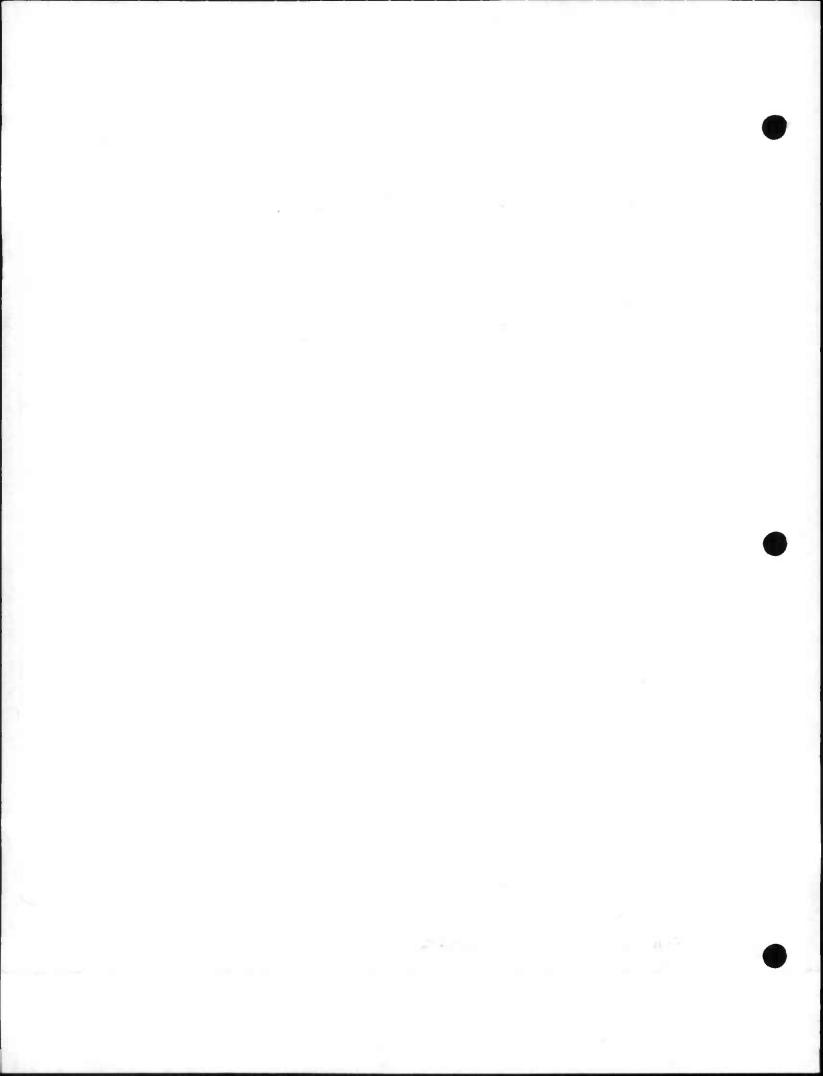
1 - STATE REGISTRAR	STATE OF MAR	RYLAND / DEPART CERTIFIC	CATE OF		NTAL HYGIEN REG. NO.	E	00042										
1. DECEDENT'S NAME (First, Middle, Last				2.	DATE OF DEATH		3. TIME OF DEATH										
James	w. P	onter			3 23		3 4:2T A										
4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. 7.	DATE OF BIRTH		BIRTHPLACE (State or Foreign										
0111 211 11500	14-24-4879 1000 75			HOURS MIN.	(Month, Day, Yoar)		Country)										
	1	75 YRS.		15	/18/1/		Mary land										
9a, FACILITY NAME (If not institution, give	. 1		DE. CITY, TOWN O	R LOCATION OF DEATI	1	9c. COUNTY	OF DEATH										
RESIDENCE OF DECEDENT	RESIDENCE OF DECEDENT																
10e. STATE 10b. COUN	LA	10c. CITY,	TOWN OR LOCAT	ON		10d. INSIDE CITY											
m0 ==			30,1+1	more			1 TES 2 NO										
10e. STREET AND NUMBER				ZIP CODE		OF WHAT COUNTRY?											
3330 Wilkens	lvenue			21229		TT	.S.A.										
11. MARITAL STATUS	12. WAS DECEDENT EX	ED ALLI C ADMET	Las Allie Deco	ENDENT OF HISPANIC	ORIONIA Manageria		RACE — American Indian.										
1 Never Merried 2 Married	FORCES? 1	YES 2	If yes, spe	city Cuban, Mexican, F		OF NO- 14	Black, White, etc.										
3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES	1 TYES	2 Alo Specify:			Specify:										
	World Wa						White										
15. DECEDENT'S ED (Specify only highest gra-		16a. DECEDENT'S U	SUAL OCCUPATION No.	N at of working	16b. KIND OF BU	BINESS/INDUS	TRY										
Elementary/Secondary (0-12)	College (1-4 or 5+)		rk done during mot retired.)														
8th Grade		Mainte	nance Ma	ın		Hotel											
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME	(First, Middle, Maiden	Surname)											
	Edker Po	rter		E.	rances E.	Ronne	n++										
19a. INFORMANT'S NAME (Type/Print)			DDDECO (C)														
	aaline			nd Number or Rural Rou	The state of the s												
Mary Alice Kie	ssiing	1207 A	nglesea	Street	Baltimor	e, Mai	ryland 21224										
20a. METHOD OF DISPOSITION 1 String 2 Cremetion 3 Re	mount from State	20b. PLACE OF DISPOSI other place)	FION (Name of cen	etery, crematory or	20c. LO	CATION — City	y or Town, State										
4 Donation 5 Other (Specify)	HOVES HOLL STATE	Lorraine H	Park Cem	eterv	Baltimore, Maryla												
21. SIGNATURE OF FUNERAL SERVICE I	JCENSEE		22. NAME AN	D ADDRESS OF FACIL	TY												
1 11 2	-	r /	Georg	e J. Gonce	e Funeral	. Home	P.A.										
I Amaa //	1 Sman	yoursh.	4001	Ritchie H	wv. Balt	imore	Md. 21225										
23. PART I. Enter the diseases, o	complications that ca	used the death. Do no															
ahock, or heart failure. List only one cause on each line.																	
IMMEDIATE CAUSE (Final disease or condition	Cordina archypmany and Randstely						Onset and Death										
resulting in death)	a. Grove	ne aring	though	ard Just	41004												
	DUE TO (OR	AS A CONSEQUENCE OF)	:														
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Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):																	
cause. Enter UNDERLYING	Compste	we berry	tail	in													
CAUSE (Disease or Injury that initiated events	C. DUÉ TO (OR	AS A CONSEQUENCE OF	: h														
resulting in death) LAST	Disher	nu slean	7 oco	eou													
	d.	, , ,															
PART II. Other aignificant condition	one contributing to de	ath but not resulting in	the underlying	cause given in Pa	rt I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS										
Malmituhr			THE ACTUAL CO.		PERFO	RMED?	AVAILABLE PRIOR TO										
1. (00.0) 1 0 0 0 0 0 0					_ 1 _ YES :	NO	OF DEATH?										
Notice da eta	h				_		1 YES 2 NO										
Dely dratin	•																
bely dratin	•	OF MAIL CASE DESERBED TO MEDICAL															
Jely dratin			26. PL	ACE OF DEATH (Check	only one)		EVANUED?										
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:		4	VANT.	/										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 UYES 2 NO	1 Inpatient 2 ER	VOutpatient 3 DOA	OTHER: 4 - Nursing Hom	e 5 🗆 Residence 6 (Other (Specify)	Kospita	1										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNES OF DEATH		VOutpatient 3 DOA URY 28b. TIME	OTHER: 4 Nursing Hom OF 28c. INJ RY WO	o 5 Residence 6 (URY AT 2	4	Kospita Injury occui	/ RED										
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25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	1 Ø Inpetient 2 GER 26a. DATE OF INJ (Month, Day,)	URY 28b. TIME (NJU)	OTHER: 4 Nursing Hom OF 28c. INJ RY WO	URY AT 2 RK? FES 2 NO	Sther (Specify) A	end Number or											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNEB OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF IN building, etc.	UURY 28b. TIME (N)JURY — At home, farm, st	OTHER: 4 Nursing Hom OF 28c. INJ RY WO 1 1	e 5 Residence 6 (URY AT RKY) VES 2 NO	Bd. DESCRIBE HOW Bd. DESCRIBE HOW B1. LOCATION (Street City or Town, State	and Number or	Rural Route Number,										
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25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNEB OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only 1 CERTIFYING PH)	28e. PLACE OF IND building, etc. 28e. To the best of my	UURY 28b. TIME (Specify) Rnowledge, death occurred	OTHER: 4 Nursing Hom OF 28c. INJ HY M 1 1	e 5 Residence 6 URY AT RK? VES 2 NO 2 NO 2 2 No 2 2	Bf. LOCATION (Street City or Yown, State the cause(e) and ma	end Number or	Rural Route Number,										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNEB OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only 1 CERTIFYING PH)	28e. DATE OF INJ (Month, Day, 1) 28e. PLACE OF IN building, etc. (SICIAN: To the best of my NER: On the basic of exami	UURY 28b. TIME (Specify) Rnowledge, death occurred	OTHER: 4 Nursing Hom OF 28c. INJ HY M 1 1	e 5 Residence 6 URY AT RK? VES 2 NO 2 NO 2 2 No 2 2	Monther (Specify) and DESCRIBE HOW Bit. LOCATION (Street City or Town, State the cause(e) and ma	end Number or	Rural Route Number,										
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25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNEB OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMI	28e. DATE OF INJ 28e. DATE OF INJ (Month, Day, 1) 28e. PLACE OF IN building, etc. SICIAN: To the best of my NER: On the basic of exami	URY 28b. TIME HNJU JURY — At home, farm, st (Specify) knowledge, death occurredination and/or investigation DF DEATH (ITEM 27) (Type,	OTHER: 4 Nursing Hom OF 28c. INJ WO 1 1 1 1 1 Treet, factory, office d at the time, date i, in my opinion, d	and place, and due to seth occured at the tin	Med. DESCRIBE HOW BIT. LOCATION (Street City or Town, State the cause(e) and ma ne, date and place, elect	end Number or	Rural Route Number, cause(e) and manner as stated. SIGNED (Month, Day, Year)										



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be within 72 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for item 28 should be detached for
IN CHICAGO, IN THE LA SECTION OF THE LA SECTION OF THE CONTROL OF THE PROPERTY

	FOR 1 - STATE REGISTRAR	STATE OF MAR		DEPAR					MENTA	L HYGIEN	E				
Į.	1. DECEDENT'S NAME (First, Middle, Last)									OF DEATH			3. TIME OF DEATH	1	
1	Marybelle PECK								Mar	ch 19.	1993	EAR	11:00 A	м	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (in yrs. lasi	t birthday)	IF UNDER			R 24 HRS.	7. DATE	OF BIRTH h, Day, Year)		BIRTHE	LACE (State or For		
	213-10-3337	1 M 2 🔀 F	81	YRS.	MONTHS	DAYS	HOURS	MIN.		8/1911	M,	,,,	Land		
- 1	Se. FACILITY NAME (If not institution, give street	et and number)			9b. CITY	, TOWN C	R LOCAT	ION OF DI	EATH		9c. COUNTY				
5	Avalon Manor Home	e Inc.			На	gers	town	1			Wash	inot	On		
EC	10a. STATE 10b. COUNTY			10c, CITY	, TOWN	OR LOCAT	ION					- 0	10d. INSIDE CITY		
E	Maryland Washi	noton		На	gerstown								LIMITS?		
AL	Maryland Washington Hagers 100. STREET AND NUMBER							10f. ZIP CODE					1 (A) YES 2 NO		
ER,	14014 Marsh Pike					21742 USA									
FUNERAL DIRECTOR		2. WAS DECEDENT EVE FORCES? 1 Y	R IN U.S. ARI	MED	13.	WAS DEC	ENDENT	OF HISPAI	NIC ORIGIN	17 (Specify Yes		. RACE	- American India	٦,	
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR O		Ю				Specify		Rican, etc.)		Specify			
													White		
1	15. DECEDENT'S EDUCAT (Specify only highest grade co	mpleted)	(Gr	ve kind of w	ork done	during mo	N st of worki	ng	16b	. KIND OF BUS	INESS/INDUS	TRY			
7	Elementary/Secondary (0-12)	College (1-4 or 5+)		k Keep						Clothir	n Mai an	fot	1.000		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			N NOC	CI,		18. MOT	HER'S NA	MF (First	Middle, Maiden		шась	ше		
C	John Peck								300 tn		our larroy				
BE (19a. INFORMANT'S NAME (Type/Print)		196	. MAILING	ADDRES	S (Street e				ber, City or Town	n, State, Zip Co	ode)			
5	Barbara A. Hinckle)	13	32 E.	Mair	Str	eet	Hand	cock.	Md.	21	750			
	20s. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Remova	I from State	20b. PLACE A	ND DATE O	FDISPOS	SITION /Na		110111	DAT		CATION - CIT	y or Tow	n, State		
	4 Donation 5 Other (Specify)		Damasc	metory or of	eme t	ery		03/2	22/93	Big	Cove '	Tanr	nery, Pa		
	21. SIGNATURE OF FUNERAL SERVICE LIGEN	ISER			22.	NAME AN	D ADDRE	SS OF FA	CILITY						
	Grove F.H.141 W.Main St.P.O.Box 368 Hancock,Md. 21750														
	23. PART I. Enter the diseases, or con	nplications that cou	sed the de	ath. Do n	Dt enter	the mo	de of dy	ing, suc	h as can	diac or respi	ratory arres	t,	Approxima	-	
	shock, or heart failure.	I one cause o	n each ilne.				_						Onset and		
		A cute Y	N400	curd	201	I S	n P	neti	w.				j		
	disease or condition resulting in death) a. A cute my o card of Infrietion DUE TO (OR AS A CONSEQUENCE OF):														
N	vith Cordine Arrest														
CERTIFICATION	Sequentially list controlling. DUE TO (OR AS A CONSEQUENCE OF):														
5	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events Due to (on as a consequence of)														
Ē	that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):														
E	- 4.					. 1							1		
A	PART ii. Other eignificant conditions of	contributing to deet	h but not re	esuiting i	n the ur	deriying	ceuse	given in	Part i.	24a. WAS AN	AUTOPSY	24b. \	WERE AUTOPSY FIN		
PHYSICIAN: MEDIC	- Aontic 3	tenos;	2						_	1 TES 2	NO		COMPLETION OF CA		
ME													1 YES 2 N	。	
ä															
5		OSPITAL:		T	OTHE	_	ACE OF D	EATH (Ch	eck only or	10)					
ΙΥS	1 YES 2 NO 1	Inpetient 2 ER/		□ DOA .	4 Nur	sing Hom		esidence	8 🗆 Othe						
	Netural 5 Pending	(Month, Day, Ye	nr)	28b. TIME INJU		-	RK?	7 200	28d. DES	CRIBE HOW II	JURY OCCUP	RED			
B	2 Accident Investigation 3 Suicide 6 Could not be	28e, PLACE OF INJ	IRY At hor	no form e	reet feet		ES 2	_ NO	201.100	ATION (Street a	and Museum and	0	on Market	-	
	4 Homicide 6 Could not be determined	building, atc. (Specify)	,, .		ory, ornor				or Town, State)	no Number of	nurar no	ate Number,		
	29e. CERTIFIER	7.1004±00=0		SS DESCRIPTION OF THE PERSON O	v/				200						
MP	(Check only one) 2 MEDICAL EXAMINED											91		. 27	
COMPLETED	2 MEDICAL EXAMINER:	- Contraction		restigation	., пттту с	garmon, de				and place, and				ned.	
H	296. SIGNATURE MIO TITLE OF CERTIFIER	V.	0		~		29c. LIC	ENSE NUM	MDER 4	107	29d. DATE S	IGNED (Month, Day, Year)	993	
2	30. NAME AND ADDRESS OF PERSON WHO C	What Eleb mine or	DEATH OTEN	4 27) (5mc	Drine!	ا ،ر		٥ ر	701	~ ~	17	14	(mek)	ソソゴ	
	not N. Fander V	man.	386	A	- La	m.P	+ .	L	بهري و	to a	Since	7:	OYT		
	TAPPETILED (Month Ann Ver)	34 HEGISTRAR'S	CHAPURE T		1040		7	100	1-1	1 Complete	VV	~!	. 10		
	muk 2 () 1992 Am	A RENIGORANIA	outre and	14				_)					- 1	



ITEMS: 23 PART I, 27, 28a-f, PER MEO 4/14/93 t.t 93 08544

		1 - STATE REGISTRAR	STATE OF MARTLA		ICATE OF	DEATH AND	MENIAL HYG REG			
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEA	гн	3. TIME OF DEATN	
		HOWARD	JOHN		PEACO	CK JR.	0 3		93 1:24 P.M	
				n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7, DATE OF BIRTI (Month, Day, Ye	N Is	BIRTHPLACE (State or Foreign Country)	
p			1 💢 M 2 🗆 F	26 YRS.	MONTHS DATA	HOURS MIR.	12/31		MARYLAND	
2, 3 should	OR		eet and number) RE HOSPITA	L	96. CITY, TOWN C	LLE		9c. COUNT	Y OF DEATH IMORE COUNTY	
₩.	ECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c CIT	Y, TOWN OR LOCAT	71041				
permit. Pages	DIR		1+ MORE	/	MiddLE	Rive	ER		10d, INSIDE CITY LIMITS? 1 YES 2 1 NO	
is.	UNERAL	44 W	1. Kings		ARK	212	20	6	N OF WHAT COUNTRY?	
215-0020 attending physician. se as the burial-transit	BY F	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 d Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	CENDENT OF NISPAI ecity Cuban, Mexics 2 W NO Specif	in, Puerto Rican, eti	ry Yee or No— 14	I. RACE — American Indian, Black, White, etc.	
attend	TO BE COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION	16a. DECEDENT'S	USUAL OCCUPATIO	ON	16b. KINO O	F BUSINESS/INOUS	STRY	
213 Blor for u		(specify only ingress grace of	College (1-4 or 5+)	Iffe. Do NOT us	work done during mo se retired.) WAIIA	MECLAN,	ic			
YLA by the be de		17. FATNER'S NAME (First, Middle, Last)	John PEAC	OCK 5	SR	16. MOTHER'S NA	ME (First, Middle, M.	HVTSN	N	
MA retair 5 shr		190. INFORMANT'S NAME (Type/Print)	TNER		ADDRESS (Street a	Number or Rural	PON PAR	Town, State, Zip Co	tiMDEF Md21121	
6 may stor, pa		20e. METHOD OF DISPOSITION 1		PLACE AND DATE of the stery, cremetory or o	OF DISPOSITION (Na	Or CREMA	2)29/23	c. LOCATION — CIT	y or Town, State	
Page ral direct		21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	26	22. NAME AN	ND ADDRESS OF FA	CILITY	Upicin	2/22/	
		1 (mmall	L. L. me	- gai	Con	inielly i	c	11 0	•	
ica at		23. PART i. Enter the disesses, or of	Indications that caused	the death. Do r	not enter the mo	de of dving au	LAYERA I	TOME OF	OO MACE AVE.	
od In		shock, or heart failure. If	lat only one cause on sa	ich iine.	not onto are	de or oying, and	Il de Cercies or	ashuaror A erres	Approximata interval Between Onset and Dasth	
24 iii niiii		disease or condition resulting in death)	DROWNING						Oliset and Dastil	
ted within completely ial, cremati		resulting in death) / a,	OUE TO (OR AS A	CONSEQUENCE O	F):					
68760, american within and completely o burial, cremain matic event,	N	Companies list conditions b.								
	AT I	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
e le la cat	CERTIFICATION									
O ding typies typies typies	Ē	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST								
		d.								
ORD: that the ed by the th and M any Inju	DICAL	PART II. Other significant conditions	contributing to death bu	it not reaulting	in the underlying	g cauas given in	PE	S AN AUTOPSY RFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
RECOl requires that seen signed of Health shows and	MED								1 YES 2 NO	
2 2 4 -	ä									
Z N	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PL	ACE OF OEATH (Ch	eck only one)			
F VIT, SICIA Certific the Sicial Certific the	IYS	1X□YES 2 □ NO	1 Inpatient 2 A ER/Outpa		4 - Nursing Hom	e 5 Residence				
NG PHYSII ng PHYSII fter this ca eath with t marked,	_	27. MANNER OF OEATN 1 Netural 5 Pending	28e. OATE OF INJURY (Month, Day, Year)	26b. TIM INJ	IURY WO	RK?	28d. OEŞCRIBE H	OW INJURY OCCUP	REO	
ON After death	B	2\\ Accident Investigation	3 - 2 6 - 9 3 280. PLACE OF INJURY	6:3	0 A 1 1 V	V—V	SUBJEC	T DROWN		
ISI TTEN TOR: after	밀	3 Suicide S Could not be 4 Nomicide determined	building, stc. (Specific	— At nome, term, s	etreet, ractory, orner	•	City or Town,	State) DARKH	Rural Route Number, LEAD CREEK	
	LE	29a. CERTIFIER 1 CERTIFYING PHYSICIA	IAN: To the best of my knowle	day doub occurs	A sa sha shee a data		BALTIM			
TO THE HOSPITAL TO THE FUNERAL De filed within 72 (COMPLETE	one) 2 MEOICAL EXAMINER:							couse(e) and menner ea stated.	
THE F	BE	296. SIGNATURE AND TITLE OF CERTIFIER	Alana,			29c. LICENSE NUI			IIGNEO (Month, Day, Year)	
2 6 3 ₹	2	30. NAME AND ADDRESS OF PERSON WHO	re of www			O.C.M.	Е.	3-2	27-1993	
		1 / () .	DQGU, W			nat D	. 1	. Mass	-11 21201	
		31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNA		enn str	eet, Ba	TTIMOL	e, Mary	yland 21201	

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE - American Indian, Black, White, etc.

1 YES 2 NO

hele

Approximate

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

3

Interval Between Onset and Death

a. BIRTHPLACE (State or Foreign

D.W.P.

993

9c. COUNTY OF DEATH

10g. CITIZEN OF WHAT COUNTRY?

7. DATE OF BIRTH (Month, Day, Year)

FOR STATE REGISTRAR

1. DECEDENT'S MAME (First, Middle, Last)

5. SEX

1 -

68760,	
BOX	
P.O.	
RECORDS, I	
F VITAL	
IVISION	

2 -78 use as the burial-transit permit. Pages 1, 2, 3 should 9h CITY TOWN OR LOCATION OF DEATH DIRECTOR 10h COUNTY 10c. CITY, TOWN OR LOCATION BALTIMORE 100. STREET AND NUMBER FUNERAL 24 nours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-If yes, specify Cubs 1 Never Married 2 Married Specify 8 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp filled in by the funeral director, page 5 should be detached for on, or removal. Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER YEARS 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) MARY SCHRADER JOSEPH STODA notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1939 CHURCH ROAD BALTO. MD. 21222 MRS. GERALDINE RUSNAK 9 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name 20c. LOCATION — City or Town, State DATE 20a. METHOD OF DISPOSITION
1
☐ Burlel 2 ☐ Cremation 3 ☐ Ren must TANTSLAUS CEM. 3-23 BALTO. MD. 4 Donation 5 Donation Other (Specify) examiner MADAME ON FUNERAL SERVICE LIE RACE TOROWS KITTUNERAL HOME 2525 FLEET ST. BALTO. MD. medical 23. PART /. Enter the diseases, or complice from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fallure. List only IMMEDIATE CAUSE (Final LANYNGRAL CA been signed by the attending physician and completely fille t, of Health and Mental Hygiene prior to burial, cremation, event, the disease or condition within resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events other DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 0 PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL shows any 1 TYES 2 NO PHYSICIAN: TO THE TOTAL DIRECTOR: After this certificate has be be filed within 72 hours after death with the State Dept. IMPORTANT: If Item 28 is marked, or Item 23 s 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 I DOA 4 - Nun ng Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28h TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 5 Pending investigation 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be determined COMPLETED 4 Homicide 29s. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 3 orem 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 102, REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

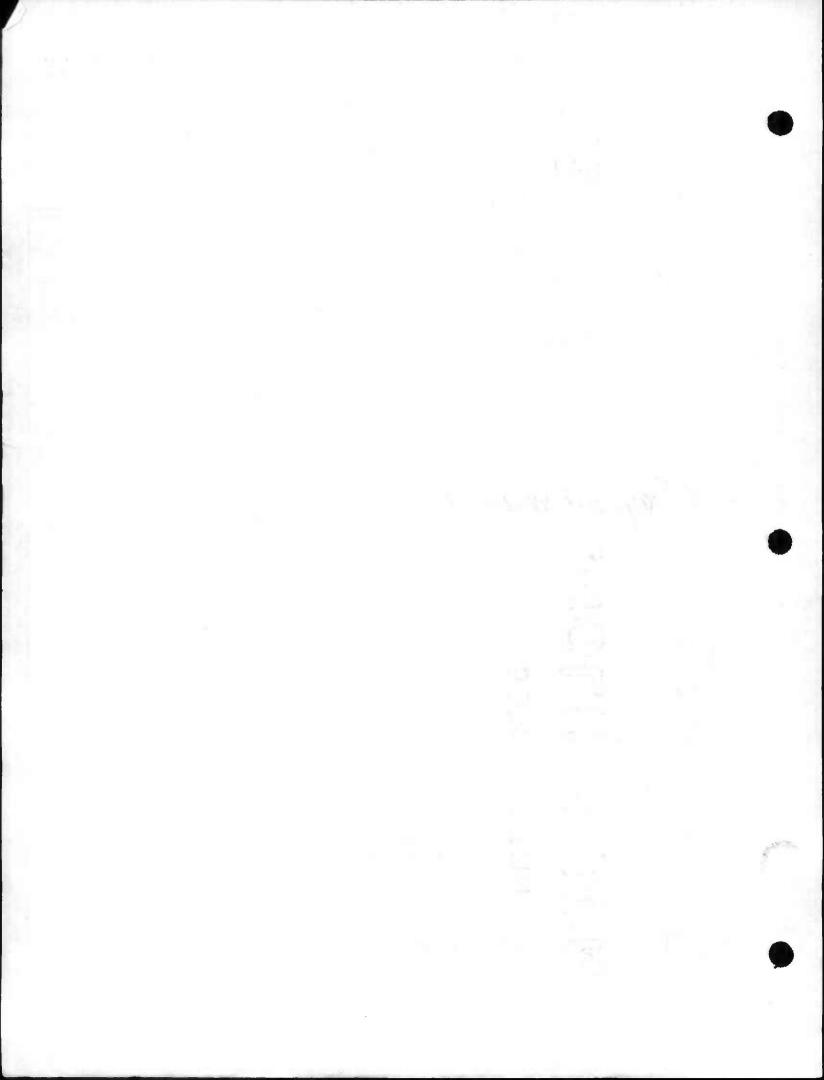
DAYS

IF UNDER 24 HRS

MARIE POZNANIAK

6. AGE (in yrs. lest birthday)

DHMH-18 Rev 1/89



ermit. Pages 1, 2, 3 should

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30 NAME AND ADD

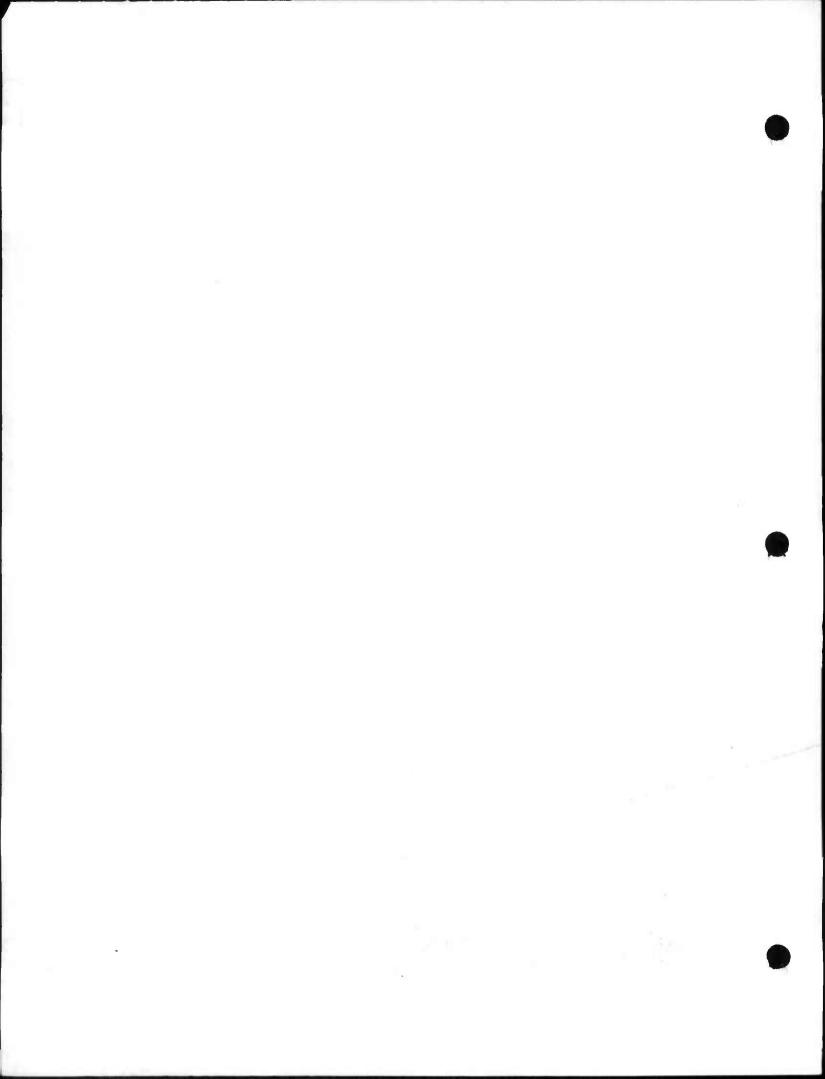
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/thin	physician and completely filled in by the funeral director, page 5 should be detached for use as the buria	rema	int,
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equires that the death certificate be executed within	e at	Aem.	my injury, or other traumatic event, the med
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10	0	De nied within 72 hours after death with the State Dept.	DRTANT: It Item 28 is marked, or Item 26 shi
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오	5	MIL	ITAN
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2	2	9	Σ

93 08546 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR MARY L. 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 03/28/93 YEAR 3. TIME OF DEATH mary Peters 0610 march 93 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign (Month, Day, Year) 09/05/1912 1 🗆 M 2 📆 212-32-3666 80 YRS. PENNSYLVANIA 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ST. AGNES HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND BALTIMORE RANDALLSTOWN 1 TES 2 XX 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3806 ELMCROFT ROAD 21133 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Marri If yes, specify Cuban, Maxican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 TES 2 X NO В 3 Widowed 4 Divorced WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) OWNER RESTAURANT 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) **JAMES** NOPULOS APHRODITE BE AMBELTSIOTIS 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 CONSTANCE BROWN (DAUGHTER) 3622 WINDFALL TERRACE ELLICOTT CITY, MD 21042 20s. METHOD OF DISPOSITION
1 X Buriel 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE WOODLAWN CEMETERY 4 Donation 5 Other (Specify) 3/31/93 WOODLAWN, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOME 1630 EDMONDSON AVE CATONSVILLE, MD 21228 23/PART I. Enter the diseases, or c ications that ceused the death. Do not enter the mode of dying, such es cerdiec or respiratory erreat, Approximete shock, or heart failure. Lift only one ceuse on each line. interval Between **IMMEDIATE CAUSE (Finel Onset and Deeth** diseese or condition_ DUE TO (OR AS A CONSEQUENCE OF): resulting in death) DUE TO (OR AS A CONSEQUENCE OF): PHYSICIAN: MEDICAL CERTIFICATION Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Bile PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one 1 YES 2 NO OTHER: Inpatient 2 - ER/Outpatient 3 - DOA e 5 Rasidenca 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 1 YES ВҰ 2 Accident 28s. PLACE OF INJURY — At home, larm, street, lactory, office building, atc. (Specify) 3 Suicida 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 193

O COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

de Davidson

28

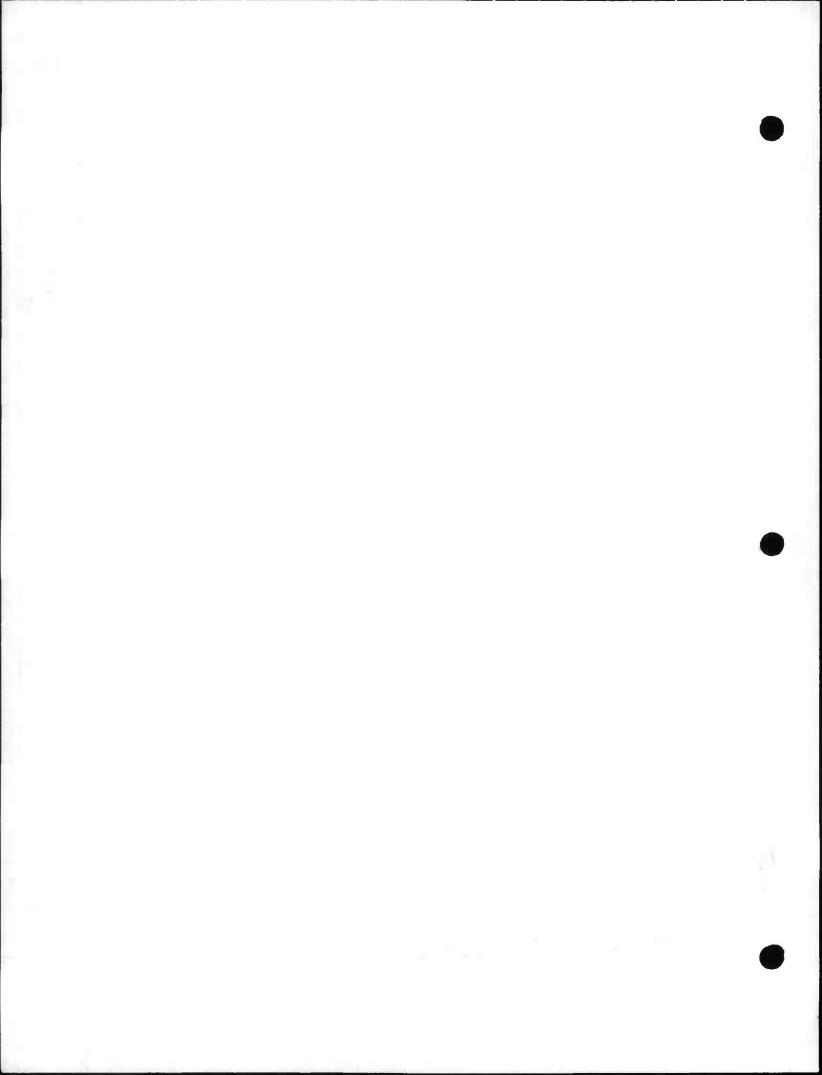


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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020	YSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE RESIDENCE OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 in	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the it be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

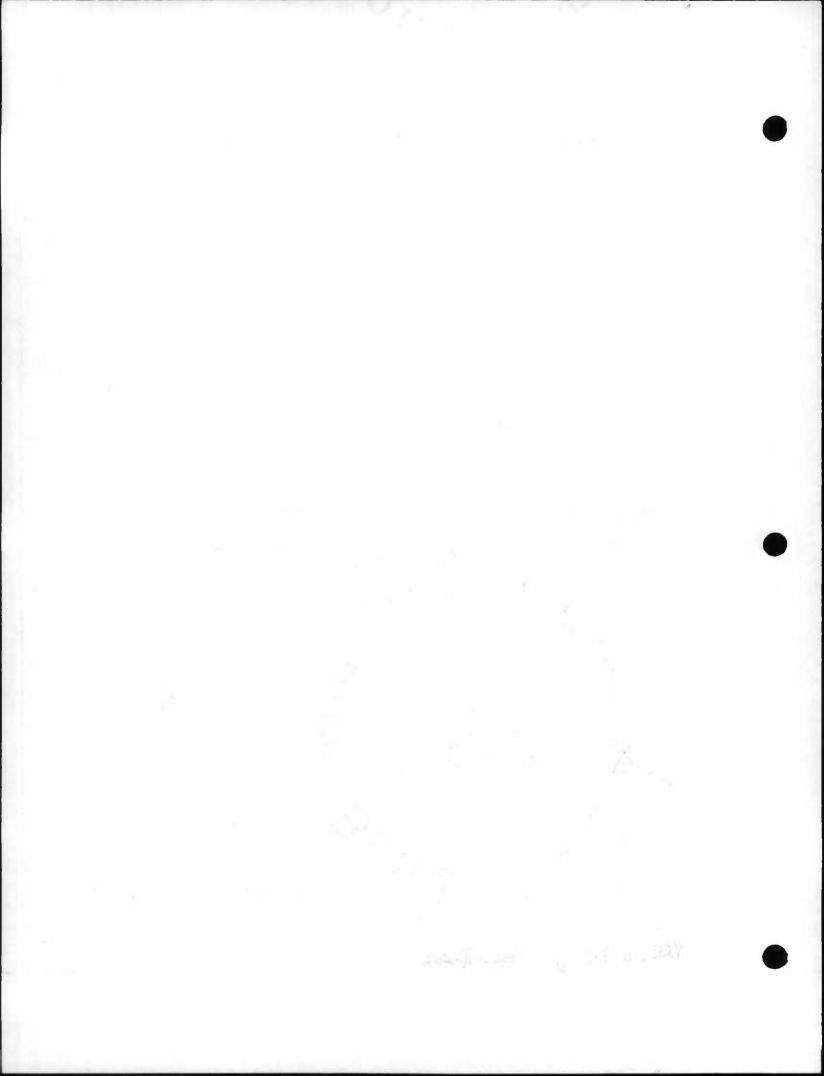
FOR					93	08547	
1 - STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMENT OF I		NTAL HYGIENI REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last			2.	DATE OF DEATH		3. TIME OF DEATH	
4. SOCIAL SECURITY NUMBER 2 (7-13-33551)	5. SEX 6. AGE (In yrs. let		IF UNDER 24 HRS. 7. HOURS MIN.	DATE OF BIRTH (Month, Day, Year)	8. BIR	THPLACE (State or Foreign intry)	
9a. FACILITY NAME (If not institution, give	street and number)		OR LOCATION OF DEATH		9c. COUNTY OF	DEATH	
Union Memorial	Lospital	Baltir	ore City				
Union Menorial RESIDENCE OF DECEDENT 10e. STATE H A 10b. COUNT H A 10b. COUN	TY	Balto	TION			10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
TOO. STREET AND NUMBER 4906 MIdwa 11. MARITAL STATUS	od Ave	10	7. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?	
3 Widowed 4 Divorced	12. WAS DECEOENT EVER IN U.S. AF FORCES? 1 YES 2 1 IF YES, GIVE WAR OR DATES	NO If yes, as	CENDENT OF HISPANIC Coeffy Cuben, Mexican, Pos 2 NO Specify:	PRIGIN? (Specify Yes verto Rican, etc.)	84	CE — American Indian, ack, White, etc.	
Specify only highest grad Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last)	le completed) (G	ECEDENT'S USUAL OCCUPATI Sive kind of work done during ma b. Do NOT use retired.)	ON ost of working	16b. KIND OF BUS	NESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) William I	Pennington		18. MOTHER'S NAME (1	iumame)		
2 HOLAND ROLL		b. MAILING ADDRESS (Street 4906 MIC	and Number or Rural Route		State, Zip Code)	121212	
20e. METHOD OF DISPOSITION 1) Burlei 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) Cemelarly, Repetitive pice) 20b. PLACE AND DATE OF DISPOSITION (Name of cemelarly, Repetitive pice) 20c. LOCATION — City or Town, State 1//93 Complete the complete of cemelarly repetitive pice)							
21. SIGNATURE OF FUNDRAL SERVICE L	(CENSEE)	22, NAME A	NO ADDRESS OF FACILITY	West	a Crack	Mars	
23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. CHF		ode of dying, such as	cardiac or respir	atory arreat,	Approximate interval Betwee Onset and Deat	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): d.							
	OUE TO (OR AS A CONSE	OUENCE OF):					
PART II. Other significant condition TOOM GT BL	OUE TO (OR AS A CONSEC	resulting in the underlyin	g cause given in Part	24a. WAS AN / PERFORI	NED?	Ab. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO	
CAUSE (Disease or injury that initiated events resulting in death) LAST PART ii. Other significant condition TOOM GT BL	oue to (OR AS A CONSEC d. one contributing to death but not r	resulting in the underlyin	g cause given in Part	PERFORI	NED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
PART ii. Other significant condition TOOM GT BL	oue to (on as a consect of the contributing to death but not not not not not not not not not no	26. P OTHER:	LACE OF OEATH (Check of	PERFORI 1 YES 2	NED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
PART II. Other significant condition TOOM GT BL 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	oue to (OR AS A CONSECTION OF TO (OR AS A CO	26. P OTHER: A Nursing Hon Seb. TIME OF INJURY W	LACE OF OEATH (Check on	PERFORI 1 YES 2	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
PART II. Other significant condition TOOM GT BL 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be	OUE TO (OR AS A CONSECT d. Ins. contributing to death but not r EECING, BNEM A HOSPITAL: 1 Dinpatient 2 ER/Outpatient 3 28e. DATE OF INJURY (Month, Day, Year)	26. P OTHER: OTHER: Nursing Hon Sb. TIME OF INJURY M 1	LACE OF OEATH (Check of the 5 Residence 6 UNRY AT 284) PK7 YES 2 NO	PERFORI 1 YES 2 only one) Other (Specify)	JURY OCCUREO	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
PART ii. Other significant condition TOOM GT BL 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 1 Netural 5 Pending 1 Netural 5 Could not be	OUE TO (OR AS A CONSECTION OF TO CONSECT	26. P OTHER: OT	LACE OF OEATH (Check of the state of the sta	PERFORI 1 YES 2 Other (Specify) 6. DESCRIBE HOW IN LOCATION (Street er City or Town, State)	MED? NO NO NO NURY OCCUREO Ind Number or Rura	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
PART II. Other significant condition TOOM GT BL 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Neture 5 Pending Investigation 3 Suicide 8 Could not be determined 4 Homicide 6 determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN 29b. SIGNATURE AND TITLE OF CERTIFIER	OUE TO (OR AS A CONSECTION OF TO CONSECT	26. P OTHER: OTHER: DOA 4 Nursing Hon 28b. TIME OF 28c. IN. W.Y. W.Y. Dome, farm, street, factory, office	LACE OF OEATH (Check of the state of the sta	PERFORI 1 YES 2 Other (Specify) 1. OESCRIBE HOW IN City or Town, State) The cause(e) and manual, date and place, and	JURY OCCUREO In Modern of Rura In the cause of the caus	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO If Route Number, If Route Number, If (a) and manner se stated.	
PART II. Other significant condition TOOM GT BL 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN 29b. SIGNATURE AND TITLE OF CERTIFIE	OUE TO (OR AS A CONSECT d. Ins. contributing to death but not re EECING, BNEM A HOSPITAL: 1 D(npatient 2 DER/Outpatient 3 28a. DATE OF INJURY At hobiding, etc. (Specify) SICIAN: To the best of my knowledge, de ER: On the best of examination end/or ER MEDICAL R	26. P OTHER: OTHER: DOA 4 Nursing Hon 28b. TIME OF 28c. IN. INJURY M 1 ome, farm, street, factory, office eath occurred at the time, date investigation, in my opinion, of	LACE OF OEATH (Check of the 5 Residence 6 INTRACT PRES) INTRACT PRES 2 NO Res 286 The many statement of the	PERFORI 1 YES 2 Other (Specify) 1. DESCRIBE HOW IN City or Town, State) De cause(e) and manu, date and place, and	JURY OCCUREO Ind Number or Rura Index ee stated, due to the cause	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO I Poute Number, (a) and manner ee stated.	



THE STATE OF THE INVISION PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	THE LIME ACCIDENTIAL After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit, Pages 1, 2, 3 should	The mean recent with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.	PORTANT. If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
2	P	z	M

	1 - STATE STATE CERTIFICATE OF DEATH CERTIFICATE OF DEATH REG. NO.
100	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH WOND BERRY RUFUS JR. 2. DATE OF DEATH MONTH DAY OVER 3. TIME OF DEATH MONTH DAY OVER 3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH Country NONTHS NONTHS NONTHS NONTHS AVB. 1. DAYS NONTHS N
TOR	Sa. FACILITY NAME (If not institution, give street and number) Sinai Hospital Baltimore City RESIDENCE OF DECEMENT
DIRECTOR	108. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. HSIDE CITY LIMITS? 11 YES 2 \(\text{NO}\) 10 NO
FUNERAL	307 N. STRICKER STREET 21223 109, CITIZEN OF WHAT COUNTRY?
B₹	11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 15. Wildowed 4 Divorced 16. YES 2 No Specify: Black 17. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 18. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify: Divorced) 19. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify: Divorced) 10. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify: Divorced) 11. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify: Divorced) 12. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify: Divorced) 14. RACE — American Indian, Black, White, etc. 15. Specify: Black, White, etc.
COMPLETED	15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 4yrs. 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Phlebotomist
BE CO	17. FATHER'S NAME (First, Middle, Lest) Rufus Woodberry Sr. 18. MOTHER'S NAME (First, Middle, Meiden Surname) Ethel Glover
5	190. INFORMANT'S NAME (Type/Print) Ethel Stevenson 190. Manung Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. Stricker Street Balto., MD. 21223
	20e. METHOD OF DISPOSITION Date Date Date Date Date
	21. SIGNATURE OF FUHERAL SERVICE LICENSEE #281 22. NAME AND ADDRESS OF FACILITY 1721-27 N. Monroe ST. E.L. Phillips F/HBalto., MD. 21217
CERTIFICATION	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one ceuse on each line. Approximate interval Between Onset and Death A DS OUE TO (OR AS A CONSEQUENCE OF): PNEUMONIA But To (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):
MEDICAL C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 21 NO
PHYSICIAN: 1	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)
IYSIC	EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MAHHER OF DEATH 286. DATE OF INJURY 287. INJURY AT DATE OF INJURY 288. DATE OF INJURY 2
ВУ Р	27. MAHNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? Actident Investigation 28d. DESCRIBE HOW INJURY OCCURED
a	3 Suicide 6 Could not be determined 28s. PLACE OF IHJURY — At home, farm, street, factory, office building, etc. (Specify) 28s. PLACE OF IHJURY — At home, farm, street, factory, office City or Town, State)
COMPLET	29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
TO BE C	290. SIGNATURE AND TUTLE OF CERTIFIER TNTERN. 29c. LICENSE NUMBER 9707 3 25 93.
É	30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VJWALA DESAI SINAI HOSPITAL
	31. DAMAR 3 0 1993 And Damas Trans S SIGN PURPLE

	1 - FOR STATE REGISTRAR	OF MARYLAND	/ DEPARTM	ENT OF H	EALTH AND	MENTAL HYGIEN	E	00049
	1. DECEDENT'S NAME (First, Middle, Last)					2 DATE OF DEATH		3. TIME OF DEATN
	HAMMOND WINFIELD R	ICE TR.				MONTH D	6 9	3 305A. H
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. I		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	0.	BIRTHPLACE (State or Foreign Country)
1 1	215-28-6384 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	□ f 63	YRS.	THS DAYS	HOURS MIN.	12/2/29		Maryland
_	9a. FACILITY NAME (If not institution, give street end num	ber)	9b	CITY, TOWN O	R LOCATION OF D	EATH	9c. COUNTY	
1 P	St. Joseph Hospital			Towson			Balt	imore
딦	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCAT	ION			10d. INSIDE CITY
DIRECTOR	Manual and B. J. I.		111					LIMITS?
	Maryland Baltimore		Towso		ZIP CODE		10q. CITIZEN	1 YES 2 NO
FUNERAL	1553 Cottage Lane				21286			
3	11. MARITAL STATUS 12. WAS OF	CEOENT EVER IN U.S. A			ENOENT OF NISPAL	NIC ORIGIN? (Specify Yes	U .S	RACE — American Indian.
BY F		S? 1 YES 2 X GIVE WAR OR DATES	NO		cify Cuban, Mexica 2 NO Specif	n, Puerto Rican, etc.)		Black, White, etc. Specify:
					Α			White
COMPLETED	15. DECEDENT'S EOUCATION (Specify only highest grade completed)	(DECEDENT'S USU Give kind of work to. Do NOT use ret	done during mos	N st of working	16b. KINO OF BUS	SINESS/INDUS	TRY
٦	Elementary/Secondary (0-12) College (1	4 or 5 +)				John H	lopkins	University
N	17. FATHER'S NAME (First, Middle, Last)	S	<u>Occupat</u>	ional	Safety (fflicer		
	The state of the s					ME (First, Middle, Maiden	Sumame)	
BE	Hammond W. rice, Sr 19a. INFORMANT'S NAME (Type/Print)	· .	SP MAILING AO	OBESS (Street a		1 Moses Route Number, City or Tow	o Otata Zin On	-
유	Marian Rice							De)
	20s. METHOD OF DISPOSITION	20b PLACE	1553 CO			DATE 20c. LO	21286	or Town, State
	1 Burlal 2 Cremation 3 Removal from St	cemetery, c	rematory or other p	olace)				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Morel	and Men	PE NAME AN	Dark 3	29/93 Hil	lendal	e, Maryland
	1/2/2/			Johns	on Funer	al Home		
	23. PART I. Enter the diseases, or complication	no that assumed the	t-att Da	8521	Loch Ray	en Blvd.	Towsor	MD 21286
	shock, or heart failure. List only D	ne cause on each lir	16.	enter the mod	de of dying, suc	n as cardlec or reepi	ratory arrest	Interval Between
	iMMEDIATE CAUSE (Finel disease or condition	ALLI	e h	1		1 T /		Onset and Death
	resulting in death)	DUE TO (OR AS A CONS	EQUENCE OF	1400	4-9/1	1 Int	e/cl	104 3 hrs.
-	- 4	heros		Lic	6 60 6	nery er	1	1 . 446
CERTIFICATION		DUE TO (OR AS A CONSI				4 67	7	direct Also
CAT	cause. Enter UNDERLYING					•		
E	that initiated events	DUE TO (OR AS A CONSI	EOUENCE OF):					
E	resulting in death) LAST							
	PART II. Other significent conditions contribute	ing to death but not	resulting in th	ne underlying	Cause given in	Part I. 24s. WAS AN	AUTTOREY	24b. WERE AUTOPSY FINDINGS
CAL			roouting in th	ic diadriying	Cadao given in	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC						1 YES 2	XAO	OF DEATH?
						—		1 TES 2 NO
MA	25. WAS CASE REFERRED TO MEDICAL			26. PL	ACE OF OEATH (Ch	eck only one)		
PHYSICIAN:	EXAMINER? 1 YES 2 NO 1 Inputte	AL:		HER:		8 Other (Specify)		
ξ	27. MANNER OF CEATH 28e. C	ATE OF INJURY	28b, TIME OF	28c. INJU	JRY AT	28d. DESCRIBE HOW I	NJURY OCCUR	EO
	1 Natural 5 Pending	fonth, Day, Year)	INJURY	M 1 V	RK? ES 2 NO			
D BY	3 Suicide 26a, P	LACE OF INJURY — AI h	noma, farm, stree	t, factory, office		281. LOCATION (Street of		Rurel Route Number,
	4 Homicide determined	unumy, etc. (Specify)				City or Town, State)		
1	29a. CERTIFIER (Check only	best of my knowledge, o	leath occurred at	The Ilme, date	and place, and due	to the cause(e) and mar	mer se stated	
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the ba							tuse(s) and manner ee stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI			GNEO (Month, Day, Year)
BE	Janis & No		,	ł	n o	1442	≥ 2	126163
일	30. NAME AND ADDRESS OF PERSON WNO COMPLETE	O CAUSE OF DEATH (IT	EM 27) (Type, Prin	()	7		13	1-0/10
	LOUIS E. G	renzer	ha.	n	1011	V. C.L.	+ 5+	B. Home
	31. DATE FILED (Month, Day, Year) 32. RE	GISTRAR'S SIGNATURE	1 14.1	13.	. ,		, - 1	21717
	MAR 3 0 1993 Julia Seu	dry But as						-120
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OF VITAL RECORDS, P.O. BOX 68760	
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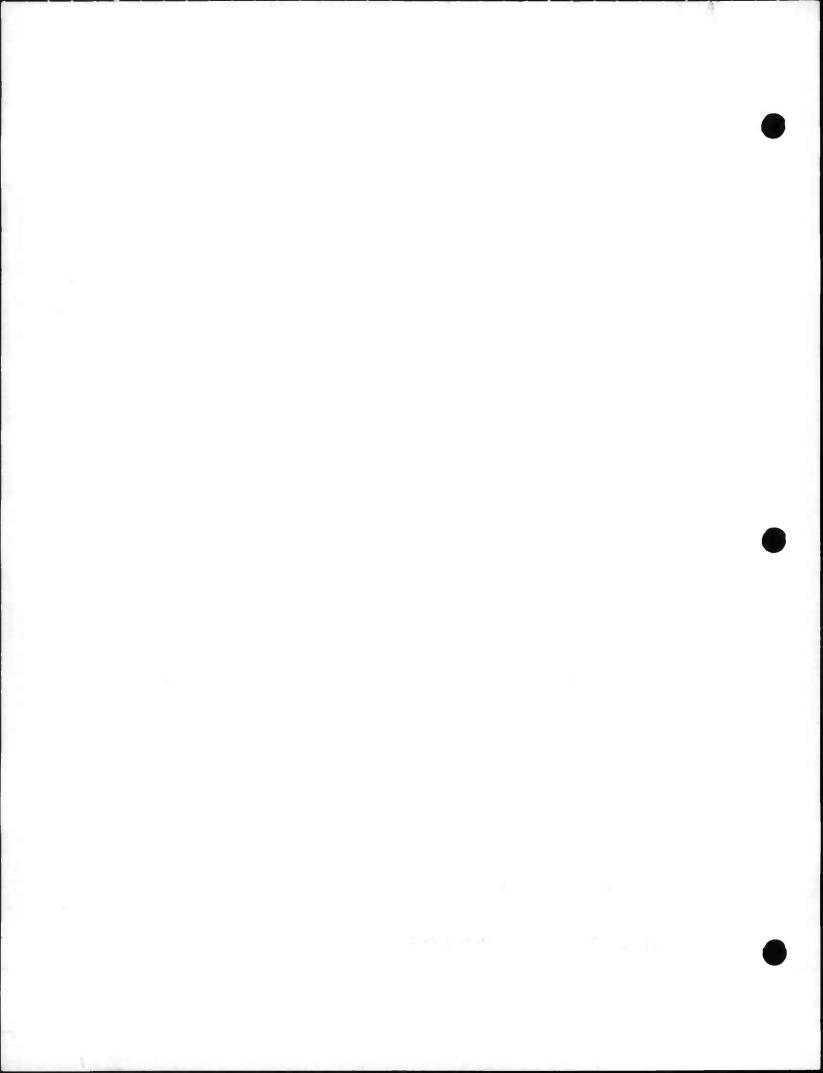
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR March 24, 1993 Deborah Randa11 10:10 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Morth, Day, Year, IF UNDER 1 YEAR IF UNDER 24 HRS. 217-66-HOURS Mari page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR nd General Hospital Baltimore City 10c CITY, TOWN OR LOCATION 10a. STATE 10b. COUNTY 10d. INSIDE CITY Maryland K YES 2 NO FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 212 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, Whits, etc. Never Married 2 Man В 4 Divorced COMPLETED 15, DECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade compl (Give kind of work do life. Do NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) once. 17. FATHER'S NAME (First, Middle, 18. MOTHER'S NAME (First, Middle, Maiden Surname notified at BE 19b. MAILING ADDRESS (Str 2 Thelma e METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of must director, lurisi 2 Cremation 3 Re nation 5 - Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY the funeral ruin 1712traumatic event, the medical 23. PART I. Enter the diseasea, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac and completely filled in by Approximate shock, or heert feilure. List only one cause on each line interval Betwe 6 IMMEDIATE CAUSE (Final Onset and Death Hygiene prior to burial, cremation, disease or condition End stage liver disease resulting in death) DUE TO (OR AS A CONSEQUENCE OF): pecuted Tuberculous peritonitis CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate the attending physician 8 cause. Enter UNDERLYING CAUSE (Disease or Injury or other that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST signed by the atte injury, PART II. Other significent conditione contributing to deeth but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? shows any 1 TYES 2X 2090 OF DEATH? 1 YES 2 NO has been s Dept. of H PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem certificate ! EXAMINER? State HOSPITAL OTHER: TO THE HOSPITAL OR ATTENDING PHYSICIAN: TO GLE ELMERAL DIRECTOR: After this certificate field within 72 hours after death with the Siz 1 Inpatient 2 ER/Outpatient 3 DOA ng Home 5 🗆 Residence 8 🗆 Other (Specify) marked, or 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED XX Natural 5 Pending ВҰ 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is COMPLETED 8 Could not be 4 Homicide determined IMPORTANT: If item 1 **CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day. 29c. LICENSE NUMBER BE n/a 9. 3 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) c/o Maryland General Hospital

Haddad, M.D

and the state of t

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the first within 20 board death with the Case of the Ca	De med when it nous are deau with the State dept. On regular mental righers provide county, constitution, or services must be notified at once. IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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ATTE	ECT	1 28
OR.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the first middle of the standard with the Charles and Mental Unique prior to had a committee of the standard of committee.	Item
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	FOR 1 - STATE REGISTRAR	STATE OF MAR				EALTH AND DEATH	MENTA		E		
	1. DECEDENT'S NAME (First, Middle, Last)		- CL	.hiiiic/	AIL OF		2. DAT	REG. NO.		1 2	TIME OF DEATH
	JC	seph	Α.		Rays:	Sr.	MON.			YEAR	3:40 PM
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last	birthdey) _#	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH			ACE (State or Foreign
	220-22-8517	1 XM 2 - F	99	YRS. MON	ITHS DAYS	HOURS MIN.		th, Day, Year) /14/18		Country)	yland
	9e. FACILITY NAME (If not institution, give str	set and number)		9b.	CITY, TOWN I	OR LOCATION OF D		, ,	9c. COUNT		
O.	136 E.Randall St.				Balto	o.City,	Md.				_
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c. CITY, TO	WN OR LOCA	TION			10d, INSIDE CITY		
E	Maryland			Ba1t	o Cit	y,Md.				1 1	LIMITS?
AL	10e. STREET AND NUMBER			242		ZIP CODE			10g. CITIZE		T COUNTRY?
FUNERAL	136 E.Rand	lall St.	_		:	21230				USA	
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— Black, V Black,						4. RACE — Black, W	American Indian, hite, etc.			
B	3. Widowed 4 Divorced	IF YES, GIVE WAR O	A DATES		1 TYES	2XXNO Specif	ly:			Specify:	White
ETED	15. DECEDENT'S EDUC	ATION	16a, DEC	EDENT'S USU	AL OCCUPATION	ON	18	b. KIND OF BUS	INESS/INDU	STRY	MILLOG
<u> </u>	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Giv	e kind of work of Do NOT use reti	done during mo ired.)	st of working					
COMPL	7th.Grade			Polic	e			Ba 1	to.C	itv.	137
	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA			Surname)		
8	John			inger		Hel					isman
2			196.			nd Number or Rural				. ,	
	Rose Lee Jackso 204. METHOD OF DISPOSITION		20h PLACE A	136 F		all St		TE 20c. LO			Chata
	4 ☐ Buriel 2 ☐ Cremation 3 ☐ Remo	val from State	cemetery cren	natory or other o	dacal	emeter	1			,	
1	21. SIGNATURE OF FUNERAL SERVICE LICE		1	u one u	22. NAME A	ID ADDRESS OF FA	ACITIA 1	L- MA	27	767.	MGC.
	►//b / (1.1/2.	lin		Mach 1	1 E	Dal	L CO.Ma	120	230	
	23. PART i. Enter the diseases, pr co	omplications that cau	sed the dea	ith. Do not e	enter the mo	de of dying, suc	th as car	diac or respi	ratory arres	E.F	ort Ave.
	shock, or heart failure. L	ist only Dne cause o	n each line.			2000			COLD . TENCH		interval Between Onset and Death
	disease or condition resulting in death)	GASTA i	nte train	al 61.	DED ING						
NO	Sequentially list conditions, Sequentially list conditions and Sequential list conditions are sequentially list conditions.										
-	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEDUENCE OF):										
¥	cause. Enter UNDERLYING	CAUSE (Disease or injury C.									
IFICAT		DUE TO (DR A	AS A CONSEQU	that initiated events DUE TO (DR AS A CONSEQUENCE OF): resulting in death) LAST							
ERTIFICAT	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (DR A	AS A CONSEQU								
L CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			sulting in th	e underlyin	r cause alven in	Part I	24. WEAN	Armoney	T 245 W	
	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions	contributing to deat	h but not re			g cause given in	Part I.	24a, WAS AN	MED3	AM	RE AUTOPSY FINDINGS NILABLE PRIOR TO MPLETION OF CAUSE
	cause. Enter UNDERLYING CAUSE (Disease or injury that inklated events resulting in death) LAST PART II. Other significant conditions	contributing to deat	th but not re	mcTis	Λ	g cause given in	Part I,		MED3	AM CO OF	AILABLE PRIOR TO MPLETION OF CAUSE DEATH?
MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or injury that inklated events resulting in death) LAST PART II. Other significant conditions	CONTRIBUTING TO deat N TO TIMOL NCIMOMA OF	observed the observed of the observed o	PROSP	MATE	g cause given in	Part I,	PERFOR	MED3	AM CO OF	AILABLE PRIOR TO MPLETION OF CAUSE
MEDICAL	CAUSE. (Disease or injury that inflated events resulting in death) LAST PART II. Other significant conditions (A) 25. WAS CASE REFERRID TO MEDICAL	CONCINE	obsine The	PROSP	N ATE RE	g cause given in	_	PERFOR	MED3	AM CO OF	AILABLE PRIOR TO MPLETION OF CAUSE DEATH?
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1993

Day, Year)

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32. PROSTRANG SIGNATURE PROPLETE

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BASTIMURE, MD.

BALTIMORE, MARYLAND 217

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

							93	08552	
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND		NT OF HEALTH		ENTAL HYGIEN REG. NO.		00002	
3		Joseph Wipla:	nd Redi	n	:	2. DATE OF DEATH DATE OF	Y YEA	3. TIME OF DEATH	
	JOSEPH W) Lec	-11			3 2	4 93	3 10:40pm	
		6. AGE (In yrs. In:	MONTH		R 24 HRS. 7	7. DATE OF BIRTH (Month, Day, Year)	8. BH	RTHPLACE (State or Foreign untry)	
	217-10-13-3					08-18-19	20 Vi	rginia	
œ	9a. FACILITY NAME I'll not institution, give street			TY, TOWN OR LOCATI			9c. COUNTY O	F OEATH'	
DIRECTOR	St. Agnes Hospital Baltimore City						N/A		
<u> </u>	10e. STATE 10b. COUNTY		10c. CITY, TOWN	N OR LOCATION		1 . 0		10d. INSIDE CITY	
5	MO Anne	Arundel	Pas	adence	2 : (MD		1 TES XX NO	
AL	To STREET AND NUMBER 707 211th Street 101. ZIP CODE 21122 109. CITIZEN OF WHAT COUNTRY								
FUNERAL	707 711	Street		2	-(1)	322	Unit	ed States	
🖺		FORCES? X X YES 2	RMED 1	3. WAS DECENDENT (ORIGIN? (Specify Yes	or No- 14. R	ACE — American Indian, lack, White, etc.	
BY	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR OATES		1 VES 2- NO		Puerto Pican, atc.)		Decify:	
	15. OECEDENT'S EDUCAT	WWII	CEDENT'S USUAL			T		White	
	(Specify only highest grade con	mpleted) (G	live kind of work dor Do NOT use retired	occupation ne during most of worki f.)	ing	16b. KIND OF BUS	BINESS/INDUSTR	Y	
7	Elementery/secondary (0-12)	College (1-4 or 5+)	Baker	•		Wonde	r Brea	d Co	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		ditte	16. MOT	HER'S NAME	(First, Middle, Meiden		a co.	
BE C	Jessie Redin			_ c	lara	Landis	,		
	19e. INFORMANT'S NAME (Type/Print)	19	b. MAILINO AODRE			ute Number, City or Town	n, State, Zip Gode)		
일	David Callicoat					sadena,			
	20s. METHOD OF DISPOSITION	20b. PLACE	AND DATE OF OISP	OSITION (Name of	7		CATION — City or		
	XX Suriel 2 Cremation 3 Remova 4 Denation 5 Other (Specify)	GIGI	Haven	Mem. Pa	ark 3	27-93	Glen B	urnie, Md.	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE CO.	2	2. NAME AND ADDRE	SS OF FACIL			eral Home	
	James F. Ha	ckman Jr.		3204 Moi	ıntai		_	na,Md.21122	
	23. PART i. Enter the diseeses, or com	plicetions that ceused the de	eth. Do not ent	er the mode of dy	ing, such a	as cardlec or reepl	ratory errest,	Approximate	
	iMMEDIATE CAUSE (Final	t only one ceuse on each line						Intervel Between Onset and Death	
	disease or condition resulting in death)	TERMINAL	NON-SH	I ALL CIES	L CAI	KUNOMA	OF LUN		
		DUE TO (OR AS A CONSE							
N	Sequentially list conditions.	POST-OBSTR		PNEUMO	NIA		1		
ERTIFICATION	if any, leading to immediate	DUE TO (OR AS A CONSE	OUENCE OF):						
2	CAUSE (Disease or injury	DUE TO (OR 10 1 00)							
Ē	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSE	OUENCE OF):						
CE	d								
- 11	PART ii. Other eignificent conditions c	ontributing to death but not i	reculting in the	underlying cause	given in Pa			24b. WERE AUTOPSY FINDINGS	
8						PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE	
ME								OF OEATH?	
ž						_			
CE	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	0711	26. PLACE OF 0	EATH (Check	only one)			
PHYSICIAN: MEDICAL	1 YES 2 10	Inpatient 2 - ER/Outpatient 3	DOA 4 N	ER: uraing Home 5 🗆 Ra	asidenca 8 [Other (Specify)			
F	27. MANNER OF OEATH 1 Netural 5 Pending	28e. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	20	8d. OESCRIBE HOW IN	JURY OCCUREO		
₽	2 Accident Investigation		M	1 YES 2	NO				
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At he building, etc. (Specify)	me, farm, street, fa	ictory, office	21	81. LOCATION (Street a City or Town, State)	nd Number or Run	ni Route Number,	
Ē									
COMPLET	(Check only	N: To the best of my knowledge, de							
8	2 MEDICAL EXAMINER: 0	On the beele of examination and/or	investigation, in my	opinion, death occur	red at the tim	ne, date end place, and	d due to the ceus	e(e) end manner ee stated.	
BE (29b. SIGNATURE AND TITLE OF CERTIFIER	do 11		29c. LICI	ENSE NUMBE	ER		ED (Month, Day, Year)	
0	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH WITTEN OF CO. CAUSE								

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MISSION OF VILAL RECORDS, P.O. BOX 68/60,	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the houshall or minimaling	CONTRACTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH EDWARD RUBIN 2:50 Pm A SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BURTH 8. BIRTHPLACE (State or Foreign 216-05-9389 1 M 2 - F HOURS TINGI YRS. MD. 83 permit. Pages 1, 2, 3 should 9e, FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH NORTH OAKS NURSING & HEALTH CENTER FUNERAL DIRECTOR PIKESVILLE BALTIMORE RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. BALTIMORE 1 TES 2 TONO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 725 MT. WILSON LANE, UNIT#36 burial-transit 21208 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 X Never Married 2 Married If yes, specify Cuben, Mexicen, Puerto Ri FORCES? 1 YES 2 BY 1 - YES 2 1 NO Specify: 3 Widowed 4 Divorced Specify: WHITE Double as the COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only higher Elementary/Secondary (0-12) College (1-4 or 5+) detached SERVANT CITY OF BALTIMORE 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Sumame) notified at SIMON RUBIN FANNIE GNIPMAN BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 GILBERT RUBIN 3402 LABYRINTH RD., BALTIMORE, MD. (21215)be 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 3/28/93 PATE 20c. LOCATION — City or Town, Stata must 1 X Burial 2 Cremation 3 Rer 4 Donation 5 Other (Specify) director. B NAI ISRAEL CONG. SOUTHERN AVENUE BALTO, MD examiner 21. SIGNATURE OF FUNERAL SERVICE (22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS. FUNERAL HOME, INC. 22 PART I. Enter the diseases, pr complications that caused the death. Dp not enter the mode of dying, such as cardiac pr respiratory arrest,

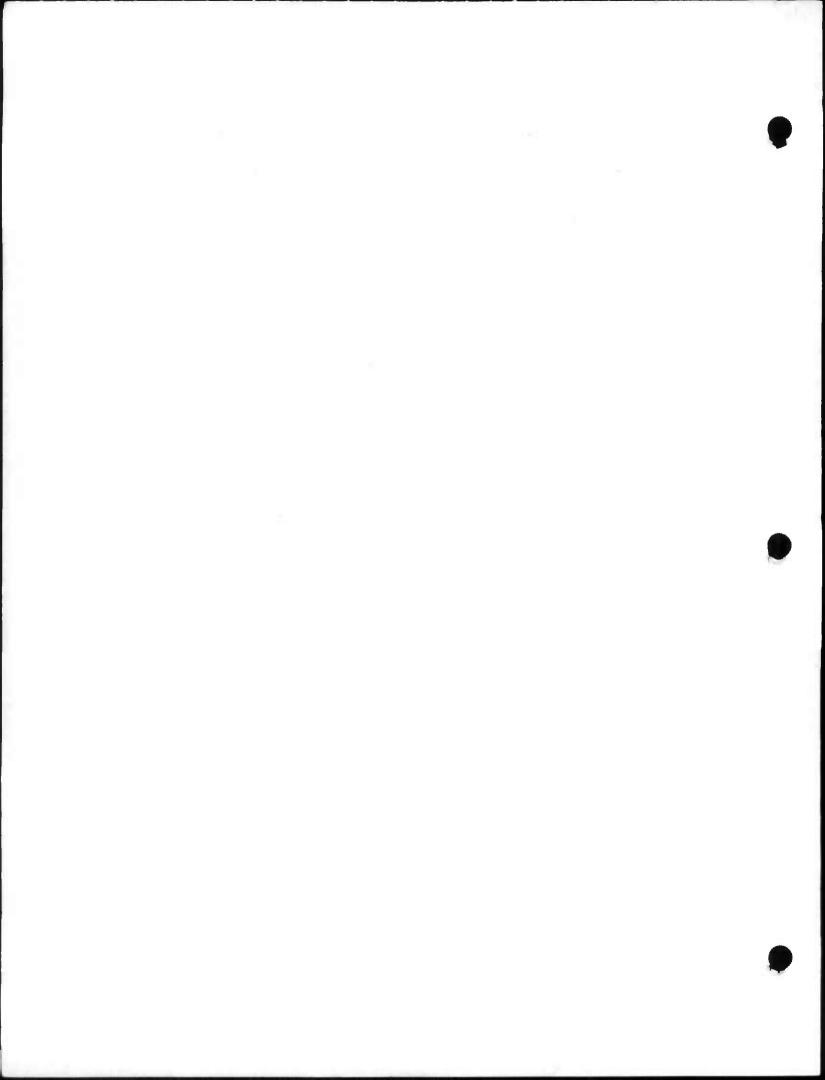
Approximately a cardiac pr respiratory arrest, medical Approximate shock, or heart fellure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (FMal Onset and Death cremation, the disease or condition_ resulting in death) event, OUE TO (OF AS A CONSEQUENCE OF): and corr burial, traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): 9 if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury prior other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 the after Mental injury. PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO 20 20 ubdu emadon 9 any Signed Health a COMPLETION DF CAUSE 1 TYES 2 NO been sign of Healt shows OF DEATH? 1 | YES 2 | NO PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item State HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER! 1 | YES 2 | 10 the the ing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF BEATH 28a. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED his with 5 Pending Investigation 1 Natural ВУ 1 YES 2 NO Affer 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) after de 3 Suicide 6 Could not be 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide DIREC ltem. 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and menner as stated. FUNERAL I within 72 h 2 MEDICAL EXAMINER: On the basic of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7. 296. SIGNATURE AND TITLE OF CONTINUES 29c. LIGENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DHMH-18 Rev 1/89

31. DATE FILED (Month, Day, Year)
MAR 3 0 1993

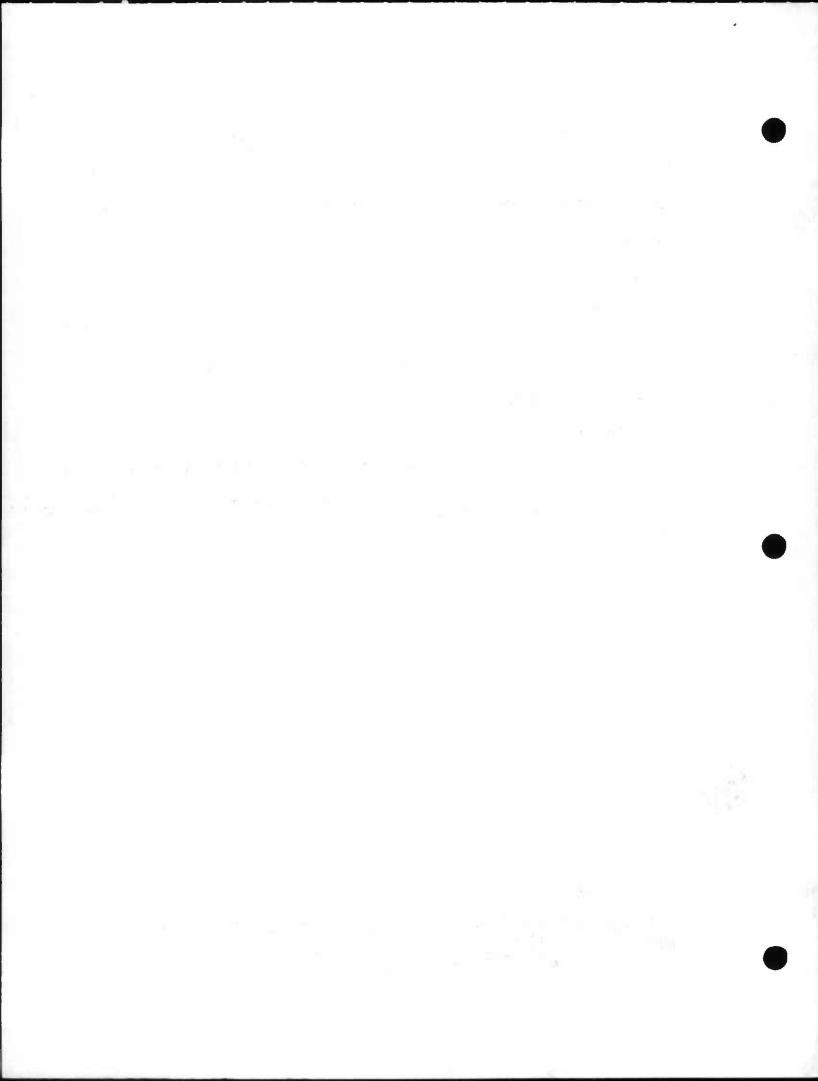
32. REGISTRAR'S SIGNATURE

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DIVISION OF VITAL RECORDS,	9	and the state of the seen signed by the a	₩.
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the de	TO THE FUNERAL DIRECTOR APPLICATION	be filed within 72 hours after
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	REGISTRAR		CERTIF	ICALE (OF DEATH		REG. NO			
1	1. DECEDENT'S NAME (First, Middle, Last)					2, DATE	OF DEATH	W	YEAR	3. TIME OF DEATH
		ARD SCHAIB	LE			Marc	h 24,	1993	LAN	
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	E (In yrs. lest birthdey)	IF UNDER 1 YE		(0.0	OF BIRTH , Day, Year)			PLACE (State or Foreign
	212-09-7315	1½ M 2 □ F 7	8 YRS.	MONTHS DA	YS HOURS MIN	Apri	1 28,1	L914	New	"Jersey
=);	9e. FACILITY NAME (If not institution, give s	treet and number)		9b. CITY, TO	WN OR LOCATION OF	DEATH		9c. COU	NTY OF D	EATH
OR	Greater Baltimore	Medical Ce	nter	Tows	on			Bal	timo	re
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	v	40.00	Y, TOWH OR LO						
DIRECTOR		imore		oenix	DCATION					10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	IMOTE		Denix	404 710 0005					1 YES 2 NO
FUNERAL		_ 7			101. ZIP CODE					HAT COUNTRY?
N N	13617 Bardon	Road 12. WAS DECEDENT EVER	IN II S ADMED	42 148 6	21131 DECENDENT OF HIS				S.A.	
	1 Never Married 2 X Merried	FORCES? 1 YES	S 2 NO	If yes	s, specify Cuban, Me	rican, Puerto F		or No-	Black	- American Indian, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 📗	YES 2 X NO Spi	ecity:		- 1	Specif	White
8	15. DECEDENT'S EDU	CATION	16a. DECEDENT'S	USUAL OCCUP	PATION	16b.	KIND OF BUS	SINESS/IND	USTRY	***************************************
山	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT us	work done during se retired.)	g most of working					
鱼	12 yrs.	5 yrs.	C.PA.	Self	Employe	ā E	Accour	iting	GI .	
COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S			7		
ш	Albert Sch	aible			Flore	nce	Gı	ılick		
TO B	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Str	eet and Number or Ru	ral Route Numb	er, City or Tow	n, State, Zip	Code)	
F	Mrs. Elizabeth L.	Schaible	Same	as #1	.0					
	20a. METHOD OF DISPOSITION 1X Burial 2 Cremetion 3 Rame	gyal from State	0b. PLACE AND DATE	OF DISPOSITION	N (Name of	OATE	20c. LO	CATION —	City or To	vn, Stete
	4 Donation 5 Dother (Specify)		emetary, cremetory or o Dulaney //	alley	Cemetery	3/29/	93 Tin	noniu	m, M	aryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	EMSEE	/ //		E AND AGORESS OF					
	1 60.1	7/		Ruck	Towson 1	Tunera	1 Home	. In	C	50 York R
	23. PART I. Enter the diseases, of	complications that cause	nd the death. Do						11101	wson_Md_2
	enock, or neart tellure.	List only one cause on	ech line.				ottoopi	y mil	- 51,	Interval Betwe
	iMMEDIATE CAUSE (Finei disease or condition	1								Onset and De
	resulting in death)	B. OUE TO (OR AS	A CONSEQUENCE OF	F)·						
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ERTIFICATION	Sequentially list conditions, if any, leeding to immediate		A CONSEQUENCE OF							-
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E	CAUSE (Disease or injury that initiated events	OUE TO (OR AS	A CONSEQUENCE OF	F):						
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O	PART II. Other significent condition	s contributing to death	but not resulting	In the under	vina seuse sives	in Boot I			T	
DICAL		a volume and good	out not resulting	in the under	ying cease given	in Pert i.	24a. WAS AN PERFOR		245.	WERE AUTOPSY FINDING AWAILABLE PRIOR TO
ILI II							1 TYES 2	□ NO		COMPLETION OF CAUSE OF DEATH?
Σ										1 TYES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL									
SICI	EXAMINER?	HOSPITAL:		OTHER:	B. PLACE OF OEATH					
3s	1 TES 2 NO	1 Inpatient 2 ER/Out 28e. OATE OF INJURY		4 - Nursing I	Home 5 Residence					
¥.	27. MANNER OF DEATH	(Month, Day, Year)		URY	INJURY AT WORK?	28d. OE\$	CRIBE HOW II	NJURY OCC	URED	
A S	27. MANNER OF DEATH 1 Netural 5 Pending			m [1]	YES 2 NO					
S.V.	1 Netural 5 Pending 2 Accident Investigation		Y — Ai home form	strant fact			CATION (Street and Number or Rural Route Number, or Town, State)			
PD W DAY	1 Netural 5 Pending	28e. PLACE OF INJUR building, etc. (Spi	RY — Ai home, ferm, secily)	street, factory, o	office			nd Number	or nural n	oute Number,
ETED OV DAY	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, etc. (Spi	ecify)			City o	r Town, State)			oute Number,
METED NOW	1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only)	28e. PLACE OF INJUR building, etc. (So	ecity) wledge, death occurry	ed at the time,	data end pleca, end c	City of	or Town, State)	ner ae atate	ød.	
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Pages 1, 2, 3 should permit. use as the burial-transit nous that dean. Page 6 may be retained by the hospital or attending physician. detached for lumeral director, page 5 should be completely filed in by the rial, cremation, or removaexecuted within to burial. attending physician and death certificate be Mental Hygiene prior een signed by the of Health and Men law requires that the this certificate has been with the State Dept. of it The PHYSICIAN: DIRECTOR: After the hours after death v IOSPITAL OR ATTENDING FJNERAL Within 72 h

2

MARGARITA A.

31. DATE FILED (Month, Day, Year) MAR 3 0 1993

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

KORELL MD.

Sule Dandon Handale

93 08555 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN 03 WILLIE SQUIRE 10:33 93 Aμ 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign h, Day 41-40-5962 1 M 2 | F HOURS 328 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR LIBERTY MEDICAL CENTER BALTIMORE CITY 10b COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARY/AMC more 1 YES 2 NO FUNERAL 100. STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-14. RACE — Am 2 Married If yes, specify Cuban, Maxican, Puarto Ri
1 YES 2 TO Specify: IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life, Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY /Spec Elementary/Secondary (0-12) College (1-4 or 5+) OW 5 e Washe once. 17. FATHER'S NAME (First, Middle, Last) NAME (First Middle Maid ĕ e BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or 2 110 Pe 20b. PLACE AND DATE OF DISPOSITION (Name of 20a. METNOD OF DISPOSITION 20c. LOCATION must 1 Donation 5 Other (Specify) Surial 2 Cremation 3 dor. examiner SNATURE OF PUNERAL SERVICE LICENSEE 054ph 20 medical 22. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate ahock, or heert feilure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Finel Onset and Death event, the disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 In ury. PART ii. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO shows any Chronic Obstructive Pulmonary Disease COMPLETION OF CAUSE OF DEATH? 1 - YES 2 NO 1 YES 2 NO INOUIRY PHYSICIAN: Item 23 s 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 □XES 2 □ NO ne 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 1 YES 2 NO BY Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 60 3 Sulcide 6 Could not be LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 28 4 Nomicide Hem 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner on stated. MPORTANT: IL 2 💢 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) end manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE heb 0 \triangleright 3-27-1993 O.C.M.E.

111 Penn Street, Baltimore, Maryland

DHMH-16 Rev 1/89

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9c. COUNTY OF CEATH

10g, CITIZEN OF WHAT COUNTRY?

USA

REG. NO.

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	0	ā	2
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	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours	FINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or n
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PORTANT

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296. SHOWATHIN AND TITLE OF CERTIFIER

1993

31. DATE FILED (Month, Day, Year)

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2. DATE OF GEATH Starner Merle S. 4. SOCIAL SECURITY NUMBER 5 SEY 7. DATE OF BIRTH (Month, Day, Year) 4-27-23 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 219 14 9327 MONTHS DAYS HOURS мм 1 M 2 F 70 permit. Pages 1, 2, 3 should 9a, FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH DIRECTOR VETERANS HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE FUNERAL 10e, STREET AND NUMBER 10f ZIP CODE 830 WEST 36th STREET 21211 use as the burlal-transit after death. Page 6 may be retained by the hospital or attending physician. 12. WAS OECEOENT EVER IN U.S. ARMEO FORCES? 1 ∑ YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-11 yes, specify Cuben, Maxican, Puerto Rican, etc.) 12 Never Married 2 Married 1 TYES 2 NO Specify BY 3 Widowed 4 Divorced WW II 0 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15 OFCEDENT'S EDUCATION (Specify only highest COMPLET n by the funeral director, page 5 should be detached for removal. Elementary/Secondary (0-12) UNKNOWN ELECTRICIAN HARRY DIAMOND LABORATORIES 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) FRANK NORWOOD STARNER 75 EFFIE FOX notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MR. ALFRED MARTINEZ 830 WEST 36th STREET, BALTIMORE, MARYLAND 21211 2 20a. METHOD OF DISPOSITION
1\(\sum_{\text{D}} \) Burlai 2 \(\sum_{\text{Cremation}} \) Tamoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State examiner must cemetery, crematory or other place)
FT. LINCOLN CEMETERY 4 Donation 5 Other (Specify) 3/30/93 BLADENS BURG. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY A. Alan Seitz, Jr. Funeral Home glan an and completely filled in by un-or to burial, cremation, or removal. 3818 ROLAND AVENUE. BALTO. 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each ilne IMMEDIATE CAUSE (Final disesse or condition Sepsis resulting in death) DUE TO (OR AS A CONSEQUENCE OF): UTI traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if sny, leading to immediata cause. Enter UNDERLYING signed by the attending physician Health and Mental Hygiene prior to CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL shows any 1 | YES 2 | NO pneumotherax Spon taneous has by Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL After this certificate hadeath with the State D marked, or Item ? 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Realdence 8 - Other (Specify) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK?
1 YES 2 NO 28a. DATE OF INJURY this c 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 2 Accident 5 Pending BY After death 3 Suicide 28a. PLACE OF INJURY — At home, term, street, fectory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 8 Could not be determined COMPLETED DIRECTOR: 4 | Homicide tem 29a CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner ea stated. =

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32. REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

CERTIFICATE OF DEATH

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, end due to the cause(a) end manner as stated.

Balt

20 S, Greene St

93 08556

3. TIME OF OEATH

BIRTHPLACE (State or Foreign Country)

Pennsylvania

10d. INSIDE CITY

14. RACE — American Indian, Black, Whita, atc.

WHITE

MARYLAND

Approximsta

24b. WERE AUTOPSY FINDINGS

AMILABLE PRIOR TO

1 TES 2 NO

OF DEATH?

29d. DATE SIGNED (Month, Day, Year)

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MBD 2 1201

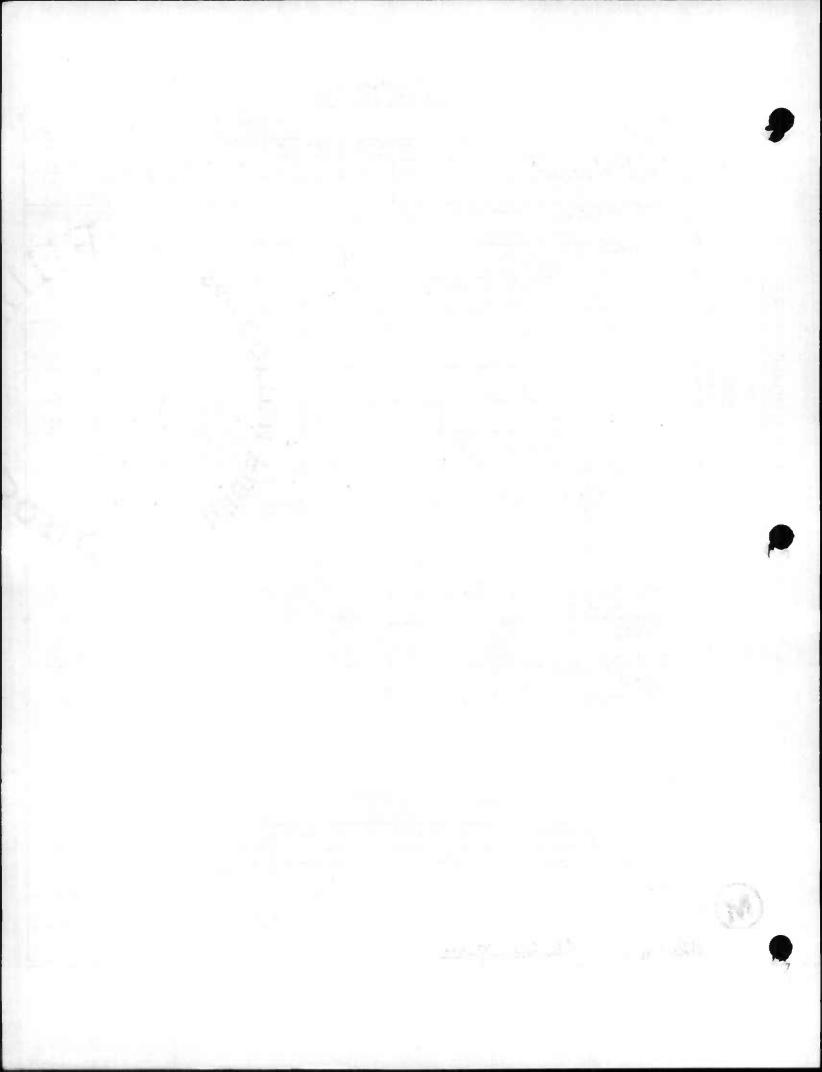
COMPLETION OF CAUSE

Interval Between Onset and Death

1 YES 2 NO

4:47Pm

DHMH-18 Rev 1/89



93 08557

DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	BALTIMORE, MARYLAND 21215-0020
. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hor	w requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.
Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	medical examiner must be notified at once.

DIRECTOR

FUNERAL

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ITEMS: 23 PART I, 27, 28a-f PER MEO G-698 4/6/93 t.t FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR 1993 ROBERT 26 LEE SAVAGE 3 12:07AM 4 SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 👿 M 2 🗀 F 214-38-4255 YRS. 11-16-1938 54 Va 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH SIDEWALK-PUBLIC STREET ANNAPOLIS ANNE ARUNDEL RESIDENCE OF DECEDEN 10a. STATE 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY Md 1 YES 2 NO Glen Burnie 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21061 USA P. O. Box 45 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify, Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 14. RACE — American Indian, Black, White atc. Specify: Black 1 Never Married 2 X Married IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 10th 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) James Richard Savage Pearl Lee Poulson

COMPLETED BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 2421 Seamon Avenue Baltimore, Md 21225 Joseph L. Savage 20a. METHOD OF DISPOSITION
1 M Burial 2 Cremation 3 Removal from State 20c. LOCATION -- City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 1 M Buriel 2 Cremation 3 L 4 Donation 5 Other (Specify) Western Star Cemetery 33093 Catonsville, Md 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
March F/H. West Glady I amer 4 4300 Wabash Avenue 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximata shock, or heart fellure. List only one ceuse on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition . PULMONARY EMBOLISM resulting In death) LONG TERM COMPLICATIONS OF MULTIPLE TRAUMATIC CERTIFICATION INJURIES Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 X YES 2 - NO W YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Residence 8 💢 Other (Specify) 1 Inpatient 2 ER/Oulpatient 3 DOA PUBLIC STREET 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 TES 2 NO PM BY -30-88 6:08 Motor Vehicle Accident 2 X Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) Crain Highway 3 Suicide 4 Homicide 29a. CERTIFIER
(Check only one)

2 | SAMEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 DemEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year)

OCME

111 Penn Street, Baltimore, Maryland

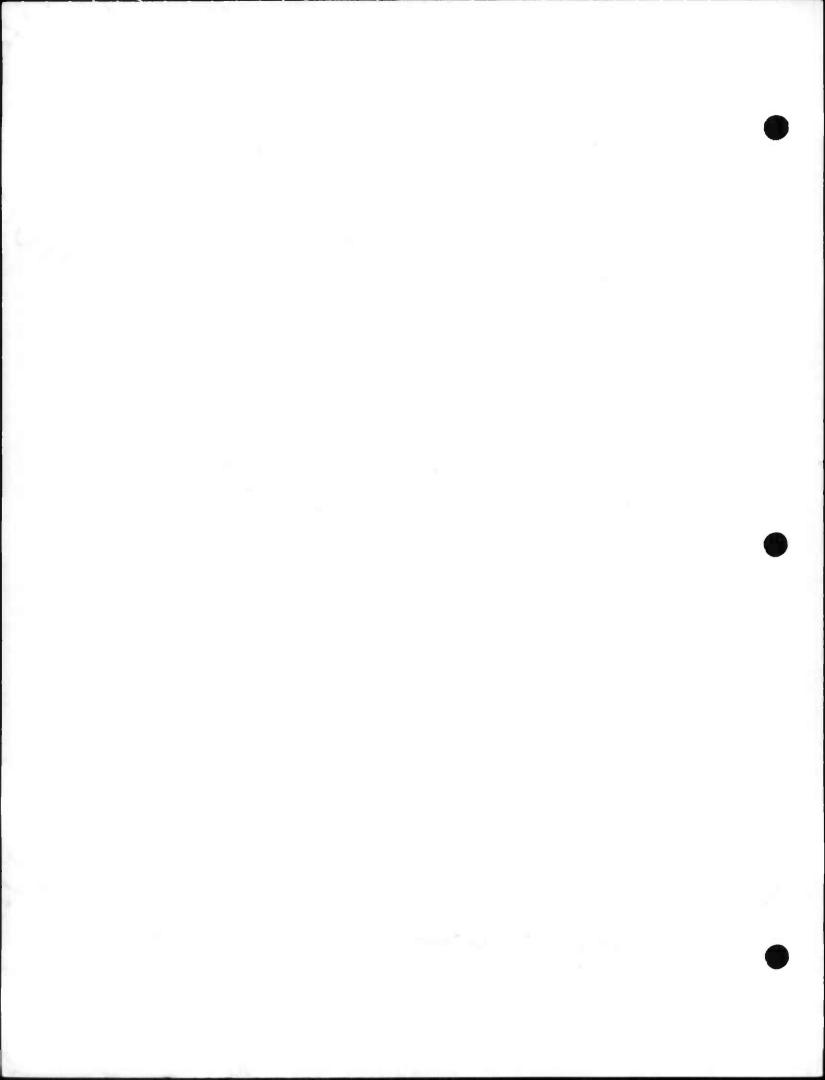
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Chut no

30. NAME AND ADDRESS OF PERSON WIND COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1993



notified at

The function DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be writin it hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It liem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. ITML OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within

	FOR	STATE OF MA	ARVI AND	/ DEDAI	TMENT	r ne u	ICALTU	AND B	SENITAL 11V	9	3 (08558		
	1 - STATE REGISTRAR		C	ERTIF	ICATI	E OF	DEAT	H H		GIENE 3. NO.				
	1. DECEDENT'S NAME (First, Middle, Leat) 2. DATE (MONTH											3. TIME OF DEATH		
	Morris Gerald Su	<u>ii th</u>							MONTH	2 8	93	1555		
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. I	ast birthday)	IF UNDER		IF UNDER		7. DATE OF BIR (Month, Day,	TH	6. BIRTHP	LACE (State or Foreign		
	216-36-2530	1 M 2 🗆 F	86	YRS.	MONTHS DAYS HOURS MIN. (MONTHS Ja.)						lnois			
_	9e. FACILITY NAME (If not institution, give :				9b. CITY	, TOWN O	R LOCATIO	N OF DE		9c. COUNTY OF OEATH				
2	Torien Nursing F	lome			Columbia Howard									
E C	10a. STATE 10b. COUNT	Υ		10c. C/1	Y, TOWN C	OR LOCAT		10d. INSIDE CITY						
DIRECTOR	Md. Howa	ard		E	lico	tt C	ity					LIMITS?		
	10e. STREET AND NUMBER				ZIP CODE			10a CIT	IAT COUNTRY?					
ER	8306 Elko Drive				210	13			USA	NA GOOMINIT				
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S.					100	IC ORIGIN? (Spec	olfy Yee or No-		- American Indian		
ВУ Е	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1		NO		If yea, spe	2 NO	Maxican	t, Puarto Rican, a	tc.)	Black, Specify.	- American Indian, White, etc.		
											орослу.	white		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Specify only highest grade completed) Separation Specify only highest grade completed Specify only hi													
Ž	Elamentary/Secondary (0-12) College (1-4 or 5+) Realtor													
ME	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname)													
	to, mother a name (riv									Vaiden Surname)				
BE	Walker D. Smith 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number og/Pural Route Number, City or Town, State, Zip Code)													
70	Dixie L. Miliner				5 4			- 11				dal a		
			1 00h DI 400	AND DATE				ET.	licott			1043		
	20s METHOD OF DISPOSITION 1 Surial 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	ovel from State	cemetery, cr	rematory of a	ther place)	TION (Nat	me of		2/	Oc. LOCATION -				
	21. SIGNATURE OF FUNERAL SERVICE LIK	CENSER?	130.	JOITTO	22	NAME AN	D AODRES	OF FAC	WI ITV	Ellicot		y, Ma.		
	· //	11	. /		G	ary	L. K	ufm	an Fune	ral Hon	es			
	23 PART Story to disagraph of the live o													
	23. PART-I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, ehock, or hear fallers. Liet only one cause on each line. Approximate interval Between													
	iMMEDIATE CAUSE (Fine) disease or condition		-		,							Onset and Death		
	resulting in death)	. Ather	oscle	rote	c C	and	1000	150	ulas o	useas	e			
		OUE TO (O	R AS A CONSE	EOUENCE O	F):									
RTIFICATION	Sequentially list conditione,	b. OUE TO (O	R AS A CONSE	OHENCE O	F).									
Ä	if any, leading to immediate cause. Entar UNDERLYING			OOLHOL O	· /·									
표	CAUSE (Diseasa or injury that initieted events	c. DUE TO (O	R AS A CONSE	OUENCE O	F):									
ERT	resulting in deeth) LAST	1												
Ö	DATE II ON a stantilla de little											1		
× I	PART II. Other significant condition		ath but not	resulting	in the un	deriying	ceuse gi	ven in P		AS AN AUTOPSY ERFORMED?		VERE AUTOPSY FINDINGS		
ă	Diabetes Heli	Itus							_ 1 D Y	ES 2 NO	C	OMPLETION OF CAUSE F DEATH?		
×	Renal Failu	re							_			YES 2 NO		
ä	Avemla													
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHE		ACE OF DE	TH (Chec	ck only one)					
C	1 YES 2 NO									y)				
IYSICI/		27. MANNED OF DEATH 28e. DATE OF INJURY (Month, Day, Year) INJU							28d. OESCRIBE I	HOW INJURY OC	CURED			
PHYSICIAN: MEDICAL	27. MANNED OF DEATH						M t YES 2 NO							
B⊀	27. MANNEP OF DEATH 1 Natural 5 Pending 2 Accident Investigation	(Month, Day,					E3 2							
ED BY	27. MANNED OF DEATH 1 Natural 5 Pending		NJURY At he	ome, ferm, a			E3 2		281. LOCATION (S City or Town,	Street and Number State)	or Rural Rou	te Number,		
ED BY	27. MANNED OF DEATH 1 Natural 5 Pending Investigation 3 Suicida 8 Could not be determined	(Month, Day, 28e. PLACE OF II building, atc	NJURY At he		itraet, facto	ory, office			City or Town,	State)		te Number,		
ED BY	27. MANNED OF DEATH 1 Natural 5 Pending Investigation 3 Suicida 8 Could not be determined 29a. CERTIFIER (Check only) 1 CERTIFYING PHYSI	(Month, Day, 28e. PLACE OF II building, atc	NJURY — At he (Specify)	eath occurre	traet, facto	ory, office	and place, a	and due to	O the cause(s) an	State) id manner as atat	ed.			
B⊀	27. MANNED OF DEATH 1 Natural 5 Pending Investigation 3 Suicida 8 Could not be determined 29a. CERTIFIER (Check only)	(Month, Day, 28e. PLACE OF II building, atc CIAN: To the best of my R: On the basis of axan	NJURY — At he (Specify)	eath occurre	traet, facto	ory, office	and place, a	and due to	O the cause(s) an	State) id manner as atat	ed.			

2

29b. SIGNATURE AND TITLE OF CERTIFIER a. Baynes M.D.

29c. LICENSE NUMBER 025 775

29d. DATE SIGNEO (Month, Day, Year)

3/28/93

Lynne A. Gayres, M.D., 14201 Laurel Park Drive, Laurel, MD.
20707



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BALTIMORE, MARYLAND 21215-0020	SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	c certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	removal.	or item 23 chave any injury or other fraumatic events are made a receipted at section of section of section and section of section and section of section
	24 hour	ni belly .	ion, or	the me
VITAL RECORDS, P.O. BOX 68760,	ate be executed within	ysician and completely	he State Dept, of Health and Mental Hygiene prior to bunial, cremation, or removal.	traumatic event
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AL	The lan	ate has	tate Dep	fam 23
N	SICIAN	certifica	h the St	
S	VG PHY	ter this	ath with	NT: If item 28 is marked
0	NOW I	TOR AL	ather de	28 ie e
3	1	E	Nours	item ?
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR SAMANTHA N. STOKES 6:27 AM 3 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year MONTHS HOURS 212-37-2761 1 M 2 F VRS July 10, 1992 Maryland 9e, FACILITY NAME (If not institution, give street and number) 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR University Hospital Baltimore RESIDENCE OF DECEDENT 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore 1X YES 2 NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 100. CITIZEN OF WHAT COUNTRY? 3121 Strickland St. 21229 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Married BY 3 Widowed 4 Divorced white 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 0 infant 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) David A. Stokes, Sr. Pamela A. Hairsine BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Pamela Hairsine 3121 Strickland St., Balto., Md. 20a. METHOD OF DISPOSITION
1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 3/ □ Donation 5 □ Other (Specify) The Green Mount Cemetery Baltimore, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE, 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Homes nen 5695 Main St., Elkridge, Md. 23. PART I. Enter the diseases or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory strest, shock, or heart failure. List only one ceuse on each line. Approximate intervai Between IMMEDIATE CAUSE (Final Onset and Death disesse or condition SEVERE PULMONARY HYPERTENSION resulting in death) DUE TO (OR AS A CONSEQUENCE OF) 8 months TRUNIUS PULMONARY VEW ATRESIA AR TERIOSUS CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 XNO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 4 Nursing Home 5 Residence 8 Other (Specify) 26e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be CD. 4 Homicide COMPLET CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end manner ee ateted. TO THE H TO THE FI De filed w 29s. LICENSE WIMBER 29d. DATE SIGNED /Mo BE 26 9 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SCOTTM. BRENNER, MA. 12 SO. GRENNE ST. SALTIMORE MA 21201 22. FEIST PAR'S STRATULE DE

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		1. DECEDENT'S NAME (First, Middle, Las							2. DATE OF I				3. TIME OF DEATH		
	Ethel Elizabeth Snow								MONTH	MONTH DAY GYEAR		YEAR	9:25 A M		
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		UNDER 1 YE		DER 24 HRS.	7. DATE OF B	HRTH		6. BIRTH	PLACE (State or Foreign		
70		218-38-1711	1 M 2 X F	78	3 YRS.	HETHS DA	YS HOURS	B MIN.	NOV. 1	. 19	14	Mar	yland		
should		9e. FACILITY NAME (If not institution, give street end number)					9b. CITY, TOWN OR LOCATION OF DEATH			7 -7	9c. COUNTY OF DEATH				
2, 3	CTOR	Washington Count	y Hospita	1		Hage	rstow	m			Wash	ning	ton		
Pages 1,	REC	10e. STATE 10b. COUN			10c. CITY, TOWN OR LOCATION					10d. INSIDE CITY			10d. INSIDE CITY		
. <u>≓</u>	ā	Maryland Was	hington		Hagerstown								LIMITS?		
permit.	ERAL	10e. STREET AND NUMBER			101. ZIP CODE						10g. CITIZ	EN OF W	HAT COUNTRY?		
020 physician. burial-transit	FUNER	13035 Little Ant			21742					USA					
020 physician burial-trar		11. MARITAL STATUS 1 Never Married 2 Merried	FORCES? 1	T EVER IN U.S. AR		13. WAS	DECENDENT	OF HISPAN	NIC ORIGIN? (Sp	pectfy Yes	or No-	14. RACE Black	— American Indian, , White, etc.		
5-0020 nding physic is the burial	B	3 Wildowed 4 Divorced	IF YES, GIVE V	MAR OR DATES		10	YES 2 XN	O Specify	y:	Specify:			White		
LAND 21215-0 the hospital or attending detached for use as the once.		15. DECEDENT'S EC	DUCATION	18e, DE	CEDENT'S US	UAL OCCUI	PATION		16b. KIN	D OF BUSI	INESS/INDU	JSTRY			
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AND he hospit detached once.	COMPL	8			Homema	aker									
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ed by the uld be o	BE	Wesley Elverson	Graham		Mary Elizabeth Hixon										
be retained ge 5 should be notified	5	190. INFORMANT'S NAME (Type/Print)							Ploute Number, C						
ப் 💆 👼 🚡	1	Gladys G. Weller						cres	Rdg.Ha				21750		
ath. Page 6 may neral director, pa		20g. METHOD OF DISPOSITION 1AJ Burlel 2 Cremation 3 Re 4 Donation 6 Other (Specify)	moval from Stata	20b. PLACE /	AND DATE OF D matory or other DA CEME	plece)	N (Neme of	02/0	DATE		ATION — C		and the second		
Page I dire		21. SIGNATURE OF FUNERAL SURVICE	HOENSEE	Matair	oa Ceme	_	E AND ADDR		24/93	Hanc	ock,	Mary	yland		
AL I IN death. Pag tuneral di tuneral di examiner	- 8	(1)00	FRE	10											
BAI rs after dea by the fur removal.		* tilli	2	Mere		Grove	F.H.14	41 W.M	ain St.P	.O.Bo	x 368	Hanco	ck,Md. 21,750		
24 hour filled in filled in the me		23. PART I. Enter the diseases, or condition that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart felture. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) BUE TO (OR AS A CONSECUENCE OF) Sequentially list anothing. Sequentially list anothing.													
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that the ted by the the and w	MEDICAL			addit dat tiot i	counting in t	ne unden	ying couse	given in		PERFORM	IED?	246.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
quires that n signed I Health a									_ 10	YES 2	NO		OF DEATH?		
has been a bept. of h	1 - 6								_				1 PES 2 NO		
AL The law e has t te Dept m 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				20	. PLACE OF	DEATH (Che	eck only one)						
SICIAN: The certificate h the State h	SIC	1 YES 2 NO	HÖSPITAL:	ER/Outpatient 3		THER: Nursing	Home 5 🗆	Residence	8 Other (Spe	eclfy)					
PHYSICIAN: The law this certificate has b with the State Dept.	РНҮ	27. MANNER OF DEATH 1 Natural 5 Pending	26e. DATE OF (Month, D	INJURY lay, Year)	28b. TIME OF		INJURY AT WORK?		28d. DESCRIB	E HOW IN.	JURY OCCI.	JRED			
After this death with	À	1 Natural 5 Pending 2 Accident Investigation					YES 2	□ NO							
TTENDI TTOR: A after d		3 Suicide 8 Coutd not be determined	26e. PLACE O building,	F INJURY At ho etc. (Specify)	me, ferm, stree	it, factory,	office		281. LOCATION City or Tox		d Number o	r Rural Ro	oute Number,		
DIRE Hour	PLET	29e. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of	my knowledge, de	ath occurred a	t the time,	iste end ple	ce, end due	to the cause(e)	end mann	or on states	4			
T T R = (Check only one) A T INFORM STATE OF THE STATE OF								end manner ee stated.							
TO THE HOSP! TO THE FUNEF be filed within	BE	2949 SIGNATURE AND TITLE OF CERTIFI	loo loo	1 "	10		29c. LI	CENSE NUM	IBER		29d. DATE	SIGNED	(Month, Day, Year)		
5 6 9 M	5	THE NAME AND ADDRESS OF PERSON W	MOCOMPLETED CADE	DE OF DEATH (ITER	4 27) (Typo, Prin	n)	1 +	<u> </u>	400		- 3	12	1193		
1		MORTIN W. G.	Allog hE.	R, JR	MP		E. A	17116	Thus	A.	HADA	en r	TOUN UN		
N		31. DATE FILED (MORTH, Day, Year)	quie buids	AN PONDER	È		- //		777	,,,	mer-1 C		, , , , ,		
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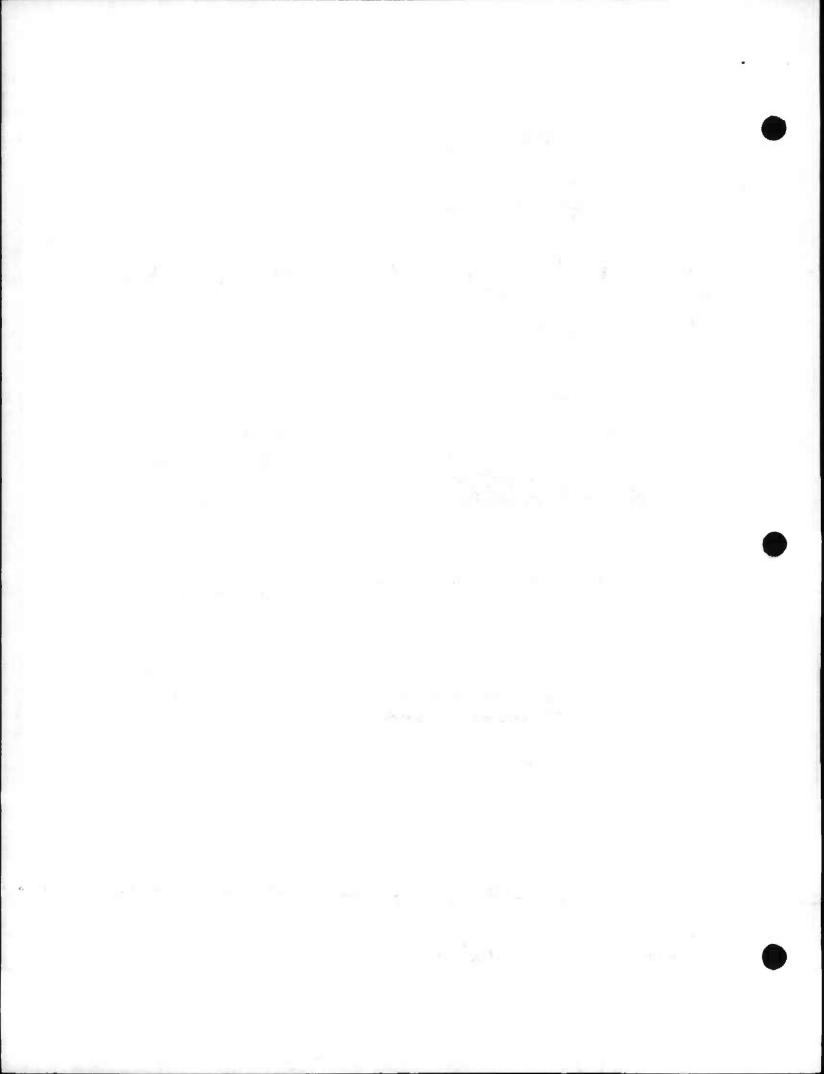
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BALTIMORE, MARYLAND 21215-0020	ter death. Page 6 may be retained by the hospital or attending physician
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If tem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF	DEATH		3.	TIME OF DEATH
- 8	LULA VIRGINIA S	IMPSON							3 -	18 -	- 1993	AR 1	0:10 p.m
	4. SOCIAL SECURITY NUMBER	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRT						HRTH	8.	BIRTHPLA	CE (State or Foreign		
1 8	234968191	1 M 2 XX	7 5	7.5 YRS. MONTHS DAYS HOURS			MIN.	Feb 25	8	WV			
·	9e. FACILITY NAME (If not institution, give	street and number)					OR LOCATIO		EATH		9c. COUNTY	OF DEAT	Н
DIRECTOR	SACRED HEART HO	SPITAL			C	umbe	erlan	d			ALLE	SANY	COUNTY
5	10a. STATE 10b. COUN		10c. CIT	Y, TOWN	OR LOCAT	TION					104	I. INSIDE CITY	
1 - 1	WV Min		K	eyse	r			1				LIMITS?	
FUNERAL	10e. STREET AND NUMBER			101	ZIP CODE					COUNTRY?			
N N	P.O. Box 513			26726				U.S.A.					
5	1 Never Married 2 Merried	12. WAS DECEDENT FORCES? 1	YES	2 2 NO		If yes, sp	ecify Cuber	ı, Mexica	NIC ORIGIN? (S	pecify Yes n, etc.)	or No— 14.	RACE — Black, W	American Indian, hite, etc.
BY	3 Wildowed 4 Divorced	IF YES, GIVE W	AR OR DATE	ES		1 TYES	2 XNO	Specify	y:			Specify: Whi	te
COMPLETED	15. DECEDENT'S ED (Specify only highest grad	UCATION	1	6a. DECEDENT'S (Give kind of					16b. KIN	D OF BUS	SINESS/INDUST		
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	se retired.)	during mo	St Of WORKING	9					
₹	3			Homemak	er					n Ho			
	17. FATHER'S NAME (First, Middle, Last) John Simpson						Vir		ME (First, Middl		Sumame) Mill		
BE	19e. INFORMANT'S NAME (Type/Print)			10h MAII INC	ADDRESS	C (Ctmat a			EIIZa Route Number, (
유	Martha Rayner			P.O.					er, WV	267		70)	
	20a. METHOD OF DISPOSITION			LACE AND DATE	OF DISPOS	SITION (Na		cybe	DATE		CATION — City	or Town,	State
	1 (A Burtel 2 Cremation 3 Hemoval from State Cametery, crematory or other place)								26726				
	21. SIGNATURE DE FUNERAL SERVICE L	ICENSEE	P				ND ADDRES			1			
	Draw 7	Snith	6		8 8	5 Sc	ick-Si outh l	mıtn Main	Funer Stree	al E	lome Levser.	WV	26726
	23. PART i. Entar the diseasea, or shock, or heart failure	complications that	caused t	ha daath. Do r									Approximata
	IMMEDIATE CAUSE (Final	. Liet Only Ona Cau	se on asc	n iina.									Intarval Between Onset and Death
	disease or condition resulting in death)	· Acu	TE	RESP	RATO	ORY	EF	3160	IRG.				
_	DUE TO (OR AS A CONSEQUENCE OF)												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate b. ASARATE OF TO RESAM BODY DUE TO (OR AS A CONSEQUENCE OF):												
S	cause. Enter UNDERLYING CAUSE (Disease or injury	с											
ᄩ	that initiated events resulting in death) LAST	DUE TO	(OR AS A C	ONSEQUENCE O	F):								
馬	Country of Case of Cas	d				_							
AL	PART ii. Other aignificant condition	ona contributing to	daath but	not reaulting	in the ur	nderiying	g cause g	iven in	Part i. 24s	. WAS AN			RE AUTOPSY FINDINGS
DIC		EUMOTH	OKA	x Ri-	· C6	E51			1[PERFOR	-	CO	MARLE PRIOR TO MPLETION OF CAUSE DEATH?
ME	7	RACHER		TGAR					_		-		YES 2 NO
					`								
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	- A		OTHER		ACE OF DE	EATH (Ch	eck only one)				
14S	1 YES 2 MO	1 Pinpetient 2 28e. DATE OF	_	ent 3 DOA	4 🗆 Nun	sing Hom		sidence	6 Other (Sp				
	1 Natural 5 Pending	(Month, Da			URY M		VES 2	l NO	28d. DESCRI	BE HOW II	NJURY OCCUR	ED	
) BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	F INJURY —	At home, ferm,	street, fect			,	281. LOCATIO	N (Street a	and Number or F	Bural Route	Number,
	4 Homicide determined	building,	etc. (Specify))					City or To	wn, State)			
12	29e. CERTIFIER (Check only	SICIAN: To the best of	my knowled	lge, death occurr	ed at the t	ima, date	end place,	end due	to the cause(e) end man	ner as stated.		
29. CERTIFIER (Check only 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner as stated.									iuse(e) en	d manner ee stated.			
296. SIGNATURE AND TITLE OF CERTIFIER								NSE NUA			29d. DATE SI	GNED (Mo	nth, Day, Year)
10 E	TO MAMP MAP TRANSPORT	9/10-/	ME				2	233	34.0		> 31	201	93
	30. NAME AND ADDRESS OF PERSON W					1	7:01-	7.	MD	2100	Car.		
	31. DATE FILED (Month, Day, Year)	TAH, M.E	R'S SIGNATI	URE		1 /	1)·V.	0,	- ,	A 133	,		
	MAR 3 0 1993	Like Bainda	1230	4.83									
		The last lates											OHMH-16 Rev 1/89



CORDS, P.O. BOX 68760,

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TO THE HOSPITAL OR ATTERNATION TO Be remained by the death certificate be executed within 24 hours after death. Page 6 may he remained by the hospital or arrange.	TO THE FUNERAL DIRECTOR TO THE FINE THE TOTAL STRENGT THE ATTENDING TO THE TOTAL STRENGT THE TOTAL STR	be filed within 72 hours after leath with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	IMPORTANT: If Item 28 🏋 marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
SAM TEMPOSIC	DR. A STANSON	ter geath with the	8 Is marked, o
HOSPITAL OR ATT	FUNERAL DIRECTO	1 within 72 hours at	TANT: If Item 24
THE	TO THE	be filed	IMPO

							93	3 0	8562		
	1 - STATE OF MARYLAI	ND / DEPARTM CERTIFIC	ENT OF H ATE OF	EALTH AND DEATH	MENTAL	HYGIEN REG. NO					
	Alpha P. Stanley				2. DATE	OF DEATH	9	3 3	TIME OF DEATH 9390 M		
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In 1 M 2 X F 8	MOI	MONTHS DAYS HOURS MIN.			Day, Year)	Country)	ACE (State or Foreign			
OR	96. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL CENTER	9b	9b. CITY, TOWN OR LOCATION OF GEATH BALTIMORE								
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10										
	MARYLAND ANNE ARUNDEL 100. STREET AND NUMBER			BURNIE	1				LIMITS?		
ERA	400 IRENE DRIVE		10f.	ZIP COOE 2106	1		U.S.A.				
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATI	2 NO	If yes, spe	ENDENT OF HISPAI city Cubsn, Mexico 2 NO Specif	NIC ORIGIN?	(Specify Yes		4. RACE — Black, V Specify:	Amarican Indian, White, stc.		
0	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		Give kind of work done during most of working				16b. KIND OF BUSINESS/INDUSTRY				
COMPLET	Elementary/Secondary (0-12)	HOUSI		HO							
CO	17. FATNER'S NAME (First, Middle, Last)			18. MOTNER'S NA		iddle, Msiden	Sumame)	12311			
BE	ALLEN W. PAGE 19a. INFORMANT'S NAME (Type/Print)	ALPHA									
2	ALLEN K. STANLEY 400 IRENE DRIVE-GLEN BURNIE, MD. 21										
		LACE AND DATE OF DI ery, crematory or other p			A/1		CATION - CH		Stats E , MD .		
	21. SIGNATURE OF FUNERAL SERVICE LICENSES	mens	22. NAME AN	D ADDRESS OF FA							
	· July a. ready		426 C	RAIN H	WY.S	.W.G	LEN B	URN	E 21061		
	23. PART I. Entar the diseases of complications that ceused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due to (or as a consequence of):										
CERTIFICATION	Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evants resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL	PART ii. Other significent conditions contributing to death but	not resulting in th	na Undarlying	cause given in		AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
					-			1	N/A		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			CE OF DEATH (Ch	eck only one			1	N/A		
2	1 YES 2 NO NO IN Inpatient 2 ER/Outpati	ent 3 DOA 4		5 Residence							
1 1	1 Natural 5 Pending (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU WOF M 1 7	IK?	28d. DE\$C	RIBE HOW II	JURY OCCU	RED			
3	2 Accident Investigation 3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — building, atc. (Specify)	At home, farm, street	t, factory, office		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				e Number,		
COMPLE	29s. CERTIFIER (Check only one) 1 XCERTIFYINO PNYSICIAN: To the best of my knowled one) 2 MEDICAL EXAMINER: On the best of examination s										
	296. SIGNATURE AND THE OF CERTIFIER		Т	29c. LICENSE NUI		nu piace, en	29d. DATE S				
0 0	Hanf Cerles	MD		AS2441		50	> 3	1/2	9/93		
	PAUL RIVERA M.D.3001 S.HA	NOVER ST	rreet-	BALTIM	ORE,	MARY:	LAND	212	25		
PAUL RIVERA M.D.3001 S.HANOVER STREET-BALTIMORE, MARYLAND 21225											

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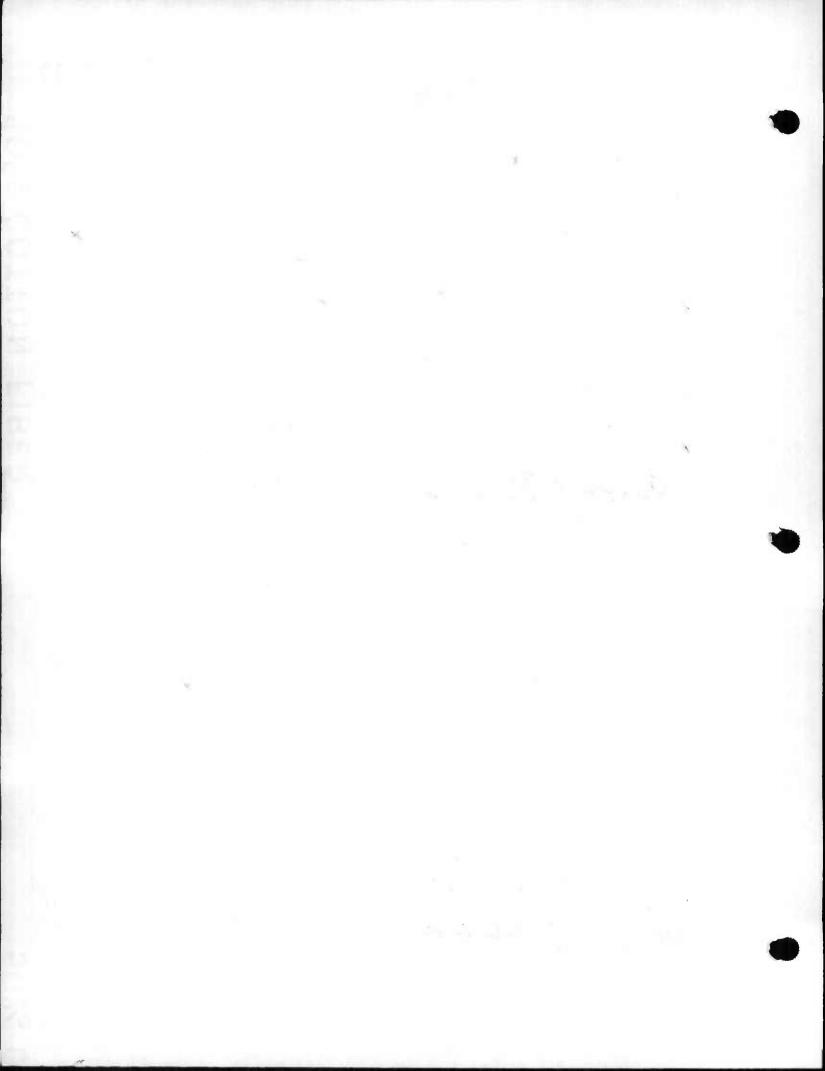
-TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a few death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. MAPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		RTMENT OF I		MENTAL HYGIEN	E 5	3 (08563	
	1. DECEDENT'S NAME (First, Middle, Last)		<u> </u>	TOATE OF	DEATH	2. DATE OF DEATH		3. TIA	AE OF DEATH	
	Josephine Smi	th				3 2.5	5 93	/EAR	230Pm	
		SEX 8. AGE (In yrs.	. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS,	7. DATE OF BIRTH			(State or Foreign	
	214-50-0792 1 9. FACILITY NAME (If not institution, give street	□ M 2 F 78	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 6-27-19	14	Mary]		
TOR	708 Newtown Dr.	•		Annapolis			Arur	ndel		
DIRECTOR	10a. STATE 10b. COUNTY	Arundel		napolis			NSIDE CITY LIMITS? YES 2 1 NO			
FUNERAL	100. STREET AND NUMBER 708 Newtown Dr.	apt. A		10	21401		10g. CITIZE	N OF WHAT C		
Β¥	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	ARMED	If yes, sp		NIC ORIGIN? (Specify Yearn, Puarto Rican, alc.)					
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	16b. KIND OF BUS	SINESS/INDUS							
N	17. FATHER'S NAME (First, Middle, Last)	Crumama)								
	17. FATHER'S NAME (First, Middle, Lest) Chesley Duvall Frances Smith									
BE	19a, INFORMANT'S NAME (Type/Print)	*	105 MAII INC	ADDRESS /Street		Route Number, City or Tow	n Otata 7in C	nofe)		
임	Josephine Holla	nd				apt. A A	nnap.	Md.		
	20a. METHOD OF DISPOSITION 1 5 Burlel 2 Cremation 3 Ramova 4 Donetion 5 Other (Specify)	I from State othe	w place)	sition (Name of ce ationa)	metery, crematory or L Cem.		cation — ch Lto.	ny or Town, St Md.	ata	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE	1		ND ADDRESS OF FA					
	· Calton C	· Wondas	1		glass F L McCul	uneral Se loh St.	ervic	е		
	23. PART I. Enter the diseases, or con shock, or heart failure. Lis immediate Cause (Final disease or condition resulting in death)		line. Ce. 1	7/	ode of dying, auc	h as cardiac or reap	iratory arres	st,	Approximata interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. PLICULAL WALLIAM DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									
PHYSICIAN: MEDICAL C	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b, WERE AUTOPSY									
ICIAN		IOSPITAL:	- a [] pos	OTHER:	LACE OF DEATH (CA	9				
	27. MANNER OF DEATH	28a. OATE OF INJURY (Month, Day, Year)	28b, T/8	ME OF 28c. IN	JURY AT ORK? YES 2 ND	6 Other (Specify) 28d. DESCRIBE HOW	NJURY OCCU	IREO		
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY — A building, etc. (Specify)	At home, farm,			261. LOCATION (Street City or Town, State)	end Number of	r Rural Routa I	Vumber,	
COMPLETED	(Orack Only	N: To the best of my knowledge On the basic of examination and							manner as stated.	
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	State	610	11100	29c. LICENSE NU	The state of the s	29d. DATE	SIGNED (Mont	h, Day, Year)	

2 DESIGNATION OF THE REAL PROPERTY. 1993

2/218



1	•	STATE REGISTRAR
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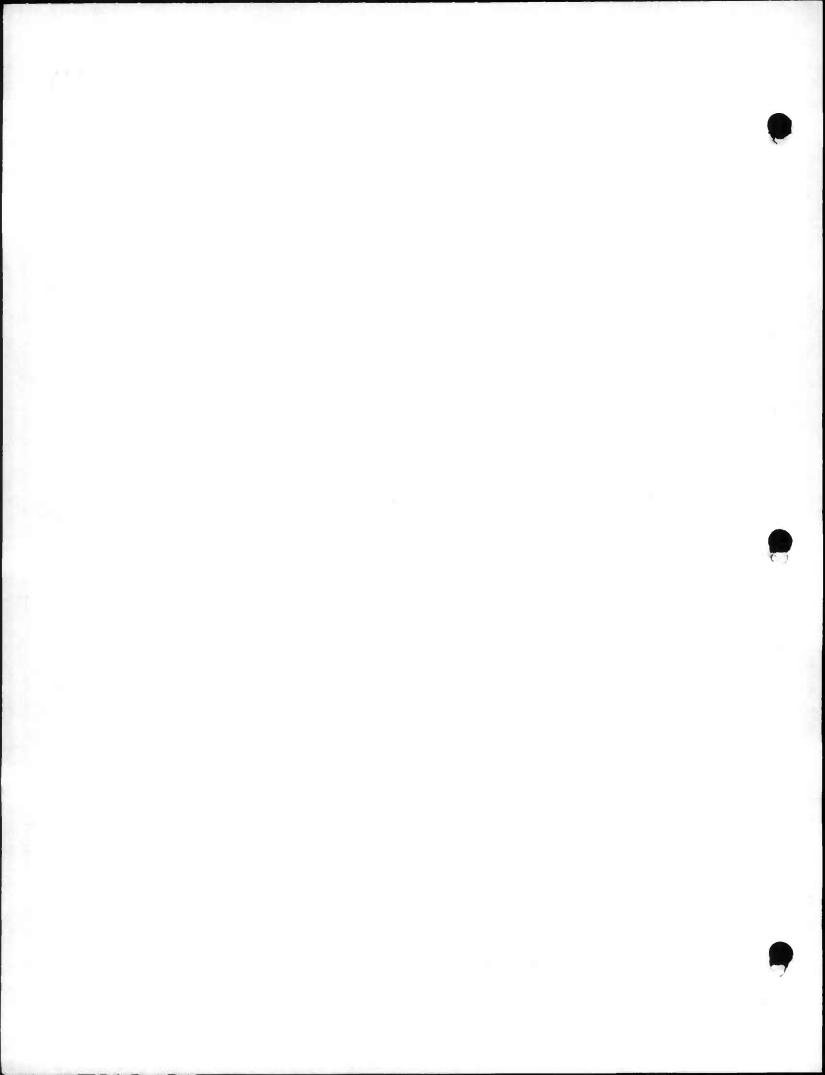
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR		CERTII	ICATE OF	DEATH	1	REG. NO.	_		
	1. DECEDENT'S NAME (First, Middle, Last)						DATE OF DEATH			3. TIME OF DEATH
	Martin Luther	Stuckert	Jr.				3-27-93		EAR	M
			(In yrs. lest birthday,	IF UNDER 1 YEAR	IF UNDER 24		ATE OF BIRTH		BIRTHP	LACE (State or Foreign
	212~05~2901	₩ 2 □ F	86 YRS.	MONTHS DAYS	HOURS	MIN. (f	Month, Day, Year) 8-20-06	0.0	Country)	elto.
	9e. FACILITY NAME (If not institution, give street a	and number)	- 00	9b. CITY, TOWN	OR LOCATION	OF DEATH	0-20-00	9c. COUNTY		
DIRECTOR	4511 Woodlea Aven		21 -	imore	OF DEATH		SC. COUNTY	OF DE	AIH	
EC	10a. STATE 10b. COUNTY		10c. Cl	TY, TOWN OR LOCA	TION					10d. INSIDE CITY
H	Md.							LIMITS?		
	10e. STREET AND NUMBER			Balti	nore					1 X YES 2 NO
FUNERAL	4511 Woodlea Avenue		21206				10g. CITIZEN OF WHAT COUNTRY?			
5	11. MARITAL STATUS 12.	WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DE	CENDENT OF H	HISPANIC OF	RIGIN? (Specify Yae			
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced FORCES? 1 YES 2 TIF YES, GIVE WAR OR DATES TO THE YES.			If yes, s	ocify Cuben, i S 2 ∰ NO	Waxican, Pu	arto Rican, etc.)	pecify Yae or No— n, etc.) 14. RACE — American Indian Black, White, etc. Specify:		r
	15. DECEDENT'S EDUCATIO	ON	16a. DECEDENT	USUAL OCCUPAT	ON		16b. KIND OF BUS	INESS/INDIES		/hite
COMPLETED	(Specify only highest grade comp	oleted) ollege (1-4 or 5+)		work done during m			TOU. KIND OF BUS	INESS/INDUS	IMT	
7	Commitment of Contract of Cont		7	11		1	Balto. G	20 5 1	E 1 0 0	the second or
2	17. FATHER'S NAME (First, Middle, Last)	l yr	Payro	11 Dept			irst, Middle, Maiden S		стес	tric
	and the second s	1 . 0								
8	Martin Luther St	uckert Sr.					Weidem			
임							Number, City or Town			
	Anna Kossman Stucke					ue Ba	ltimore,	Md2	1206	5
	20s, METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Removal I	Irom Stata Cer	b. PLACE AND DATE	OF DISPOSITION (Nother place)	ame of	- } 1	DATE 20c. LOC	ATION - City	or Tow	n, Slate
	4 Donation 5 Other (Specify)		Parkwood	Cemete:			-31 B	altimo	ore,	MD.
	21. SIGNATURE OF FUNERAL SERVICE LICENSE	7 /		22. NAME A	ND ADDRESS	OF FACILITY		15 DE	1	D 1
	* tathleen M.	nursh	1.	John	° M-11	lor				Road M21206
П	23. PART I. Enter the diseases, or comp	dications that cause	tha death, Dp	not antar the me	da of dving.	such as	cardiac or manir	atory arrest	Le,r	Approximata
	IMMEDIATE CAUSE (Final disesse or condition resulting in death)	only one cause og a	ach lina.	land	}				•	interval Batwean Onset and Death
		DUE TO (OR AS	A CONSEQUENCE (P):	17520					1 500
z	•	(in	nam	(Onlas	0	معم	No			5
윤	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A	A CONSEQUENCE O	n:						27
2	cause, Entar UNDERLYING CAUSE (Disease or Injury	alle	nel	معمد						
<u> </u>	that initiated eventa	DUE TO (OR AS A	A CONSEQUENCE O	r);						
CERTIFICATION	resulting in death) LAST									
	PART II. Other significant conditions con	Otribution to death I	aut not requiting	In the conduct to						
DICAL	6 - 60	minuting to death b				n in Part i	I. 24a. WAS AN A PERFORM		- A	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO
	- Jerese Inc	mouton	Ingy	elena			t TYES 2	□ NO		COMPLETION OF CAUSE OF DEATH?
Σ	- chrone	emplus	em						1	TYES 2 NO
ÿ i		, 1								
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL:			ACE OF DEAT	H (Check onl	ly one)			
S		Inpatient 2 ER/Out	patient 3 🖺 DOA	OTHER: 4 Nursing Non	o 5 Aeside	ence 6 🗆 C	Other (Specify)			
Į Į	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	26b. Til		URY AT	26d.	DESCRIBE HOW IN	JURY OCCUR	ED	
8	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, 18ar)	100		PRK? YES 2 N	0				- 1
	3 Suicide 6 Could not be	260. PLACE OF INJURY	/ — Al home, lerm,	streel, factory, offic	•	261.1	LOCATION (Street ar	nd Number or I	Rumil Rou	ute Number
	4 Nomicide datarmined	building, etc. (Spec	спу)				City or Town, State)			
الا	290. CERTIFIER	To the best of a few								
COMPLETED	(Check only one) 1 CERTIFYING PHYSICIAN: 2 MEDICAL EXAMINER: On	the basis of exemination	neage, asm occur	ed at the time, date	and place, and	d due to the	cause(s) and mann	er an atated.		
8	2 MEDICAL EXAMINER: On	the best of examination	er and/or investigati	on, in my opinion, o	eath occured a	it lhe time, o	data and place, and	dua to Iha ca	suse(s) a	and manner as stated.
W	29b. SIGNATURE AND TITLE OF CERTIFIER	1 . 0	0 /	1 10	29c. LICENSE					Aonth, Day, Year)
0	- June	J Una	1	11	DOL	280		▶ 03.	-29	-93
	30. NAME AND ADDRESS OF PERSON WHO COM				- 1-	-0				
	5601 LOCH RAVER		BALT	O MD	212	39				
J	31. DATE FILED (Month Pay, Year)	32. REGISTRAR'S SIGN		12						

DHMH-16 Rev 1/89

office and the burial-transit permit. Pages 1, 2, 3 should

BALTIMORE, MARYLAND 24215-0020

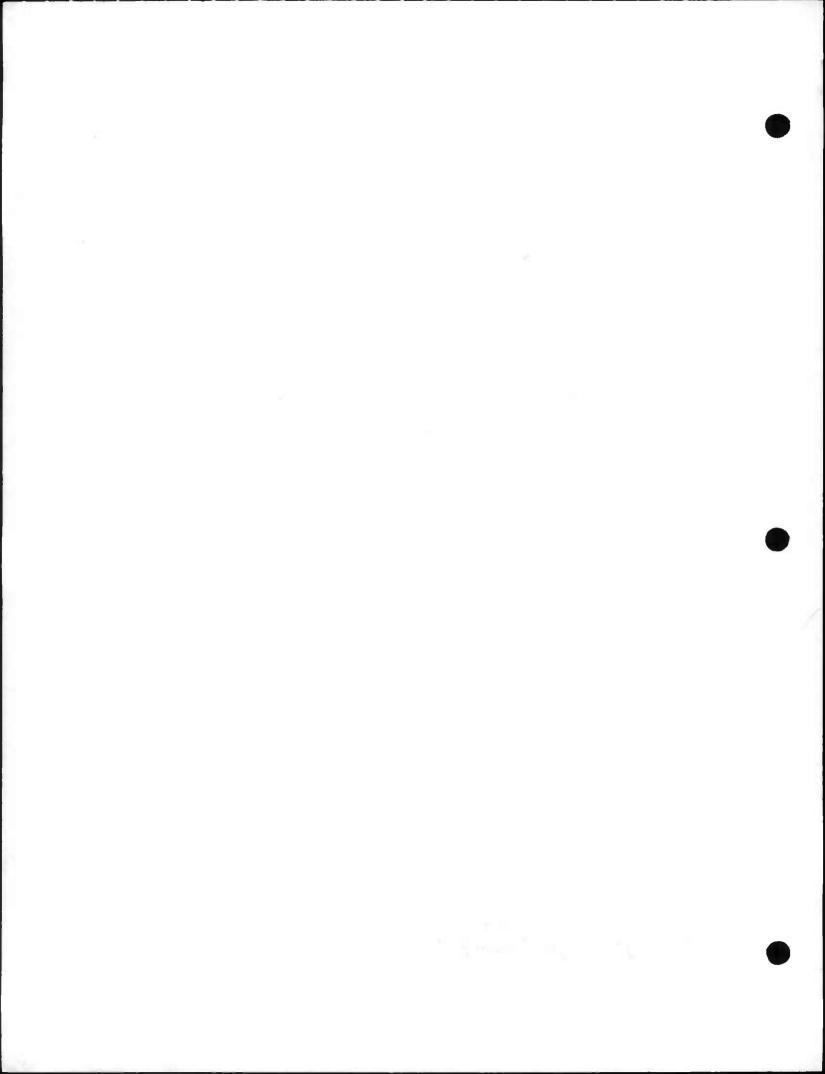


attending physician. Use as the bunal-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the incent of the state of the state of the state of the attention of the physician and completely filled in by the funeral director, page 5 should be showned be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

	1 - FOR STATE REGISTRAR	STATE OF MARY	AND / DEPARTI			MENTAL HYGIEN		00303	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	CONCETTA	ALICE		HADLE		<u>03</u>	<u>8</u> <u>93</u>	2.:45 AN M	
1	4. SOCIAL SECURITY NUMBER 213.16.4872	1 🗆 M 2 💢 F 7		F UNDER 1 YEAR DNTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	MARCH 24,	Count	HPLACE (State or Foreign ry) RYLAND	
~	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								
DIRECTOR	NORTH ARUNDEL I RESIDENCE OF DECEDENT 100. STATE 100. COUNT	<u>A.A</u>	. COUNTY						
	MARYLAND ANNE ARUNDEL SEVERN							10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	100. STREET AND NUMBER 101. ZIP CODE 7929 ANDORICK DRIVE 21144					10g. CITIZEN OF WHAT COUNTRY?			
J.	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IC ORIGIN? (Specify Yee			
ВУ	1 Never Merried 2 Married 3 X Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 YES	2 NO Specify:	, Puerto Rican, etc.)	Spec		
밀	15. DECEDENT'S EDU (Specify only highest grade	CATION a completed)	16a. DECEDENT'S US	UAL OCCUPATIO	N st of working	16b. KIND OF BUS	SINESS/INDUSTRY		
COMPLETED	Elementary/Secondary (0-12) 10 th	College (1-4 or 5 +) NONE	MERCHANT	SELF	EMPLOYED	TROPHY	AND SPO	ORTS SHOP	
ő	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NAM	NE (First, Middle, Malden			
BE	SAMUEL PICCO				PHILOM	ENA DETOR	RIE		
2	190. INFORMANT'S NAME (Type/Print) WARREN F. SHADLI	E TR				Oute Number, City or Town	,,	1//	
	20g. METHOD OF DISPOSITION	200	D. PLACE AND DATE OF	DISPOSITION (Nei	me of	EVERN, MAR	CATION - City or To		
	1X Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)		HAVEN HAVEN			3-31 GLEN			
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	A.	22. NAME AN	D ADDRESS OF FAC		N FUNERA	L HOME	
	Janue)	- sub	do	1 SECO	ND AVE.	S.W. GLEN	BURNIE,		
23. PART / Enter the diseases, or compilications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, abock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) S. DUE TO (OR AS A CONSEQUENCE OF): LUNG CAUCEM								Approximata interval Between Onset and Daath	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): d.								
AL	PART II. Other significant condition	is contributing to dasth t	out not resulting in t	tha underlying	causa given in F	Part I. 24s. WAS AN /	AUTOPSY 24h	WERE AUTOPSY FINDINGS	
DIC	Amir Fi	BMLLATIO	1 N W177	+ /LA	TO RES	PEN 1 VES 2	10.00	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY	
PHYSICIAN: MEDIC	SET GULE		rmia	144	RIKTLE	my		1 TYES 2 MO	
IAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			38. PL	ACE OF DEATH (Chec	ok only one)			
SIC	1 YES 2 NO	HOSPITAL:		THER:	5 🗆 Residence 6				
BY PH	27. NANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME O	Y WOF		28d. DESCRIBE HOW IN	JURY OCCURED		
	2 Accident Investigation 3 Suicide 6 Could not be determined	28s. PLACE OF INJURY building, etc. (Spec	/ — At home, term, stre- city)	et, factory, office		281. LOCATION (Street er City or Town, Stete)	nd Number or Rural F	Poute Number,	
Ë	29e. CERTIFIER (Check only 1 CERTIFYING PHYSI	ICIAN: To the beat of my know	ledge, death occurred a	t the time detail	and place, and due t	a the cause(s) and man			
COMPLETED		ER: On the beele of examination) end manner ee stated.	
BE	296 SIGNATURE AND TITLE OF CERTIFIES	'hs Mul	ms		29c. LICENSE NUME	2-2/5	29d. DATE SIGNED	(Mogtil, Day, Year)	
2	30 NAME AND ADDRESS OF PERSON WH				D 100	7	-		
		LEN, M.D./770	OG QUARTER	FIELD F	RD./GLEN	BURNIE, MI	<u>21061</u>		
	MAR 3 0 1993 &	hid Davidoon for							



FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

	1 - REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO	_			
	1. DECEDENT'S NAME (First, Middle, Last) GENE FRA	NK		ZUCH		2. DATE OF DEATH DO 3		93 ^{XEAR}	3. TIME OF DEATH D9:50 AM M	
1	4. SOCIAL SECURITY NUMBER 288-12-5386	5. SEX 6. A	GE (in yrs. last birthday) O YRS.		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		6. BIRTH	IPLACE (State or Foreign ry)	
OR	90. FACILITY NAME (If not institution, give s NORTH ARUNDEL HO	street end number)		50	OR LOCATION OF D	<u> 1 09−21−192</u> EATH	9c. COU	OHIO INTY OF DEATH A.A. COUNTY		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE MARYLAND ANN	v E ARUNDEL	ion of it, found on Education						10d. INSIDE CITY	
	10a. STREET AND NUMBER 7625 MARCY DRIVE				10f. ZIP CODE 10g.			1 ☐ YES 2 🛣 NO ITIZEN OF WHAT COUNTRY? .S.A.		
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVE FORCES? 1 X Y	WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO			NIC ORIGIN? (Specify Yea an, Puerto Rican, etc.)			E — American Indian, k, White, etc.	
D BY	3 Wildowed 4 Divorced 15. DECEDENT'S EDU	IF YES, GIVE WAR OF WW II		1 - YES	S 2 NO Specif				WHITE	
COMPLETED	(Specify only highest grade	completed) College (1-4 or 5+) 7	(Give kind of life, Do NOT u	work done during made retired.)	Ost of working ABILITATI ALIST	ION STATE			AND	
BE CO	17. FATHER'S NAME (First, Middle, Last) JOSEPH SZUCH					ME (First, Middle, Maiden	Surname) F(UTO		
5	190. INFORMANT'S NAME (Type/Print) ALMA C. SZUCH					Route Number, City or Town			60	
	20e. METHOD OF DISPOSITION 1 Burlal 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State	20b. PLACE AND DATE cometery, cremetory or c MD. VETER	OF DISPOSITION (Nother place)	eme of	DATE 20c. LO	CATION -	City or To		
	21. SIGNATURE OF FUNERAL BEHVICE LIC	Sto			OND AVE.	SINGLES , S.W., GLEN			RAL HOME MD.21061	
	23. PART i. Enter the diseases, Dr of shock, or heart felture. IMMEDIATE CAUSE (Final	complications that cau List only one cause or	sed the death. Do n each line.	not anter the mo	ode of dying, suc	h as cardiac or reapi	ratory an	reat,	Approximata interval Between Onset and Death	
	disease or condition resulting in death) a. Die to use as a consequence on:									
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING									
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): a. Uniform Confirmation									
DICAL C	PART II. Other algnificant conditions contributing to death burget resulting in the underlying clause given in Part i. 24s. WAS AN AUTOPSY PERFORMEO? AMILIBRE PRIOR TO									
: MED						1 _ YES 2	□ NO		COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	2 000	OTHER:	ACE OF DEATH (Ch					
	27. MANNER OF DEATH 1 Netural 5 Pending	28s. DATE OF INJUR (Month, Day, Yea	Y 28b. TIM	IE OF 28c. IN.		6 Other (Specify) 28d. DESCRIBE HOW IP	JURY OC	CURED		
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJU building, etc. (S	JRY — At home, ferm, specify)			28f. LOCATION (Street e City or Town, State)	nd Number	or Rural R	loute Number,	
COMPLETED	299. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC (Check only one) 2 CERTIFYING PHYSIC (Check only one)	CIAN: To the best of my kn	owledge, death occurrention and/or investigation	ed at the time, date	end place, end due	to the cause(e) end men time, date end place, end	ner as atai	led.) and manner se stated,	
BE	296. SIGNATURE AND TIPLE OF CENTURES	Don	- 2	4/	29c. LICENSE NUI		29d. DAT		(Month, Day, Year)	
٥	PAUL ROSOFF, M.D				N BURNIE	, MARYLAND	210	61		
	PAUL ROSOFF, M.D./7575 RITCHIE HWY, S.E./GLEN BURNIE, MARYLAND 21061 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE MAR 3 0 1993									

BALTIMORE, MARYLAND 21216-TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

transit permit. Pages 1, 2, 3 should

DHMH-16 Rev 1/89

FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 24 93 03 JOHN SMITH 7:10pm JR. W 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign HOURS 1 M 2 □ F YRS 220-03-4167 4/23/192 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give 1201LIGHT ST 96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY 9c. COUNTY OF DEATH BALTIMORE DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Balto.City,Md. YYES 2 NO permit. FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1201 Light st The burial-transit USA 21230 nding physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? TO YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—II yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND/21215-0020 1 Never Married 2 Married 1 YES NO Specify BY Widowed 4 Divorced Specify: W.W.2 White JU 984 ETED 18s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b, KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) COMPL be retained by the hosp to Unknown the funeral director, page 5 should be detached Parts Division General Motors once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 젊 John BE Marie Kloid Dorothy notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Danny McClung 395 Dublin Dr. Glen Burnie, Md. 21060 9 20s. METHOD OF DISPOSITION

Grantin 3 Granoval from State

4 Donation 5 Other (Specify) 24 hours after death. Page 6 may filled in by the funeral director, pag 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must Vet. Cemt. Crownsville 3/31 Crownsville, Md. Md 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Balto.Md. 21230 McCully Funeral Home,130 E.Fort Com medical 23. PART I. Enter the diseases, or complications that ceused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between 0 IMMEDIATE CAUSE (Final Onset and Daath the disease or condition resulting in death) HYPERTONSILG ATHORSCHEMOTIC CASSIOVASCHIMA the attending physician and completely if Mental Hygiene prior to burial, crematic executed within event, RECORDS, P.O. BOX 68760, QUE TO (OR AS A CONSEQUENCE OF): DISEASE traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by t Health and AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? any 1 YES 2 | NO shows HOADINY 1 YES 2 NO been of h PHYSICIAN: The law r has be Dept. DIVISION OF VITAL 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item the State L DR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate 2 hours after death with the State if Item 28 is marked, or Item HOSPITAL: OTHER: YES 2 NO 1 | Inpatient 2 | ER/Outpetient 3 | DOA ne 5 🗆 Rasidence 6 🗀 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c, INJURY AT WORK? 28d. DEȘCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER

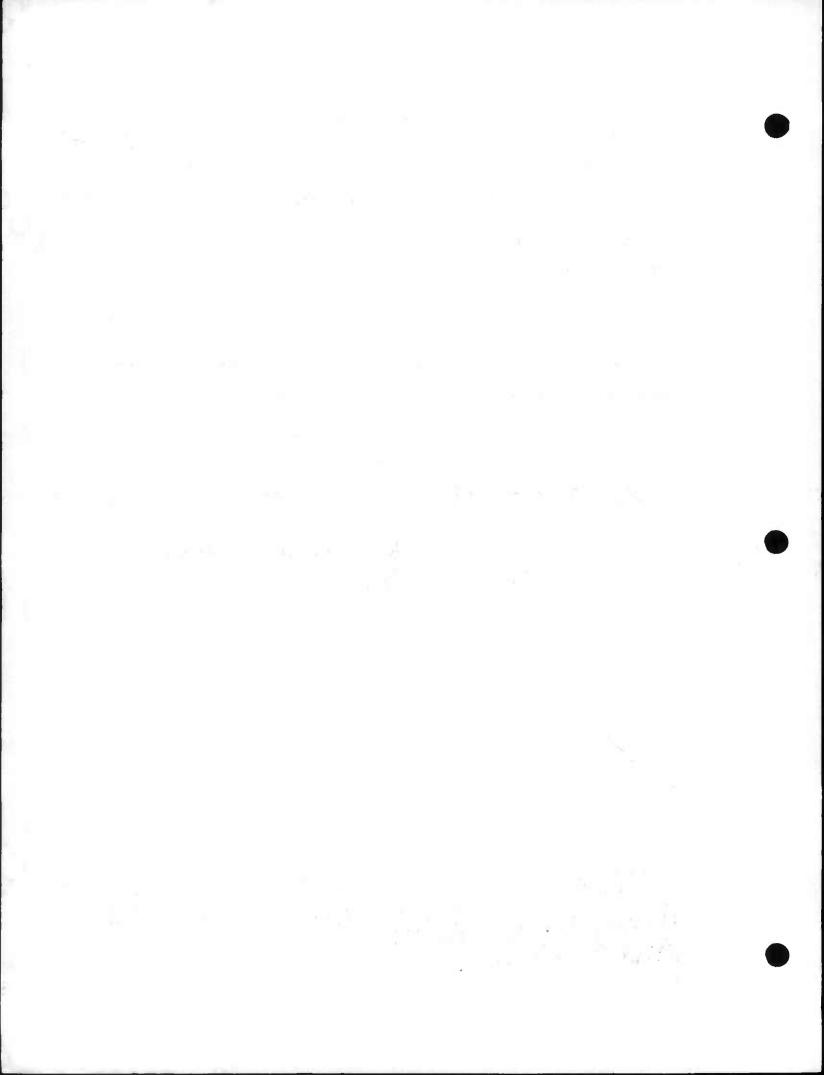
(Chack only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. FUNERAL (
within 72 h HOSPITAL TO THE HOSPITA
TO THE FUNERAL
DE filed within 73
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 296. WHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE O.C.M.E. 3-25-1993 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARY DOUTD 111 Penn Street, Baltimore, Maryland D. KoRow w 21201 31. DATE FILED (MOORD, Day, Year) 1993 32. HEGISTRAND SIGNATURE PORCE

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	BALTIMORE, MARYLAND 212-15-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the focus for a first physicial	s after death. Page 6 may be retained by the focus of or an along physicia
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be dejuthed the burial-to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	by the funeral director, page 5 should be defected forms as the burial-tremoval.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	dical examiner must be notified at once.

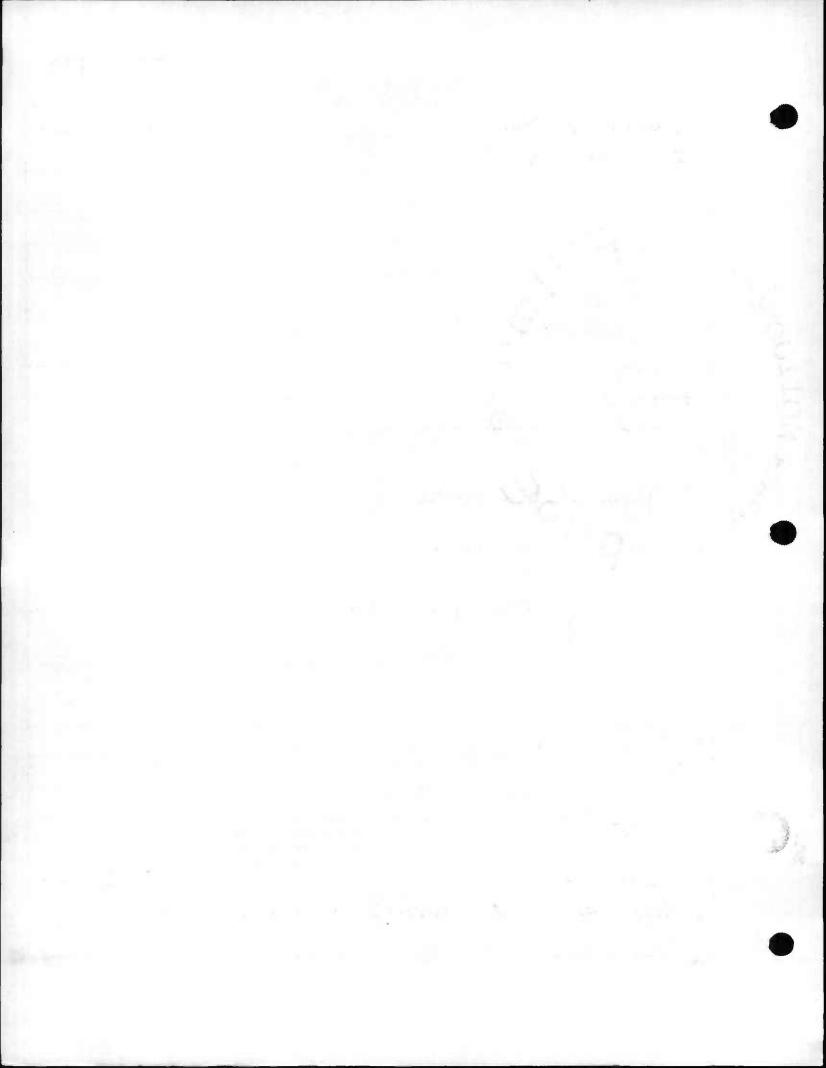
1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 1. DECEDENT'S NAME (First, Middle, Last) 3. DATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 3. DATE OF DEATH MONTH DAY 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BHITH (Month, Day, Year) 1. DAYS HOURS MIN.	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. MONTHS 1. MONTHS	
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 1	
18-42-7309 1 0 M 2 F 48 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year)	5 95 12 P M
	9c. COUNTY OF DEATH
Baltimore County Gen. Hosp. Randallstown RESIDENCE OF DECEDENT 100. STATE 100. COUNTY Maryland Anne Arundel Pasadena	Balto., County
10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY
	1 WES AND
Toe. STREET AND NUMBER 10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
Top. Street and number 272 Creek Blvd. 10f. Zip code 21122 11. Marital status 12. Was decedent ever in u.s. armed Forces? 1 Ves 2 V No 13. Was decembent of hispanic origin? (Specify Yea or forces) 14. Never Marital 2 Marylad 15. Never Marital 2 Marylad 16. Street and number 15. Was decembent of hispanic origin? (Specify Yea or forces) 17. Never Marylad 18. Was decembent of hispanic origin? (Specify Yea or forces)	U.S.A.
	or No.— 14. RACE — American Indian, Black, White, stc.
3 □ Widowed XX Divorced IF YES, GIVE WAR OR DATES 1 □ YES XX NO Specify:	Specify: White
15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 16b. KIND OF BUSINI	
(Specify only highest grade completed) [Give kind of work done during most of working life. Do NOT use retired.) [Give kind of work done during most of working life. Do NOT use retired.)	
	Construction
19e INFORMANT'S NAME (Sma(Print)	
Melisa Claar 8833 Falcon Ridge Dr., Rand	
1 0000 rateon Midde Dr., Mand	
20a. METHOD OF DISPOSITION 1 Burlel 2 V Scremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCAT	ATION — City or Town, Stata
20a. METHOD OF DISPOSITION 1 □ Burial 2XIX remetion 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE of DISPOSITION (Name of cametery, cremetory or other place) Metro Crematory, Inc. 3-24-93 C	
20s. METHOD OF DISPOSITION 1 Grandler 2 XIX remettor 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crametory or other place) Metro Crematory, Inc. 3-24-93 C 21. SIGNATUME OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MCCU11	Catonsville, Md.
20a. METHOD OF DISPOSITION 1	Catonsville, Md. Ly Funeral Home asadena, Md. 21122
20a. METHOD OF DISPOSITION 1	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 Mory arrest, Approximate
20s. METHOD OF DISPOSITION 1 Burial 2X X remetion 3 Removal from Stata 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line.	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 Approximate interval Between
20s. METHOD OF DISPOSITION 1 Grand 20st Name of Commeter, crametory of other (Specify) 20s. METHOD OF DISPOSITION 1 Grand 20st Name of Commeter, crametory of other place) 20s. Method Crematory, Inc. 3-24-93 C 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MCCull 3204 Mountain Rd., Pack Name of Commeter, Crametory of the place) 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line.	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 Approximate interval Between
20s. METHOD OF DISPOSITION 1 Gurial 2X (Scremetton 3 Removal from State Commeter), cremetory or other place) 4 Donatton 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MCCU11 32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) DUE TO (OR AS A CONSEQUENCE OF):	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 Approximate interval Between
20s. METHOD OF DISPOSITION 1 Gurial 2X (Scremetton 3 Removal from State Commeter), cremetory or other place) 4 Donatton 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MCCU11 32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) DUE TO (OR AS A CONSEQUENCE OF):	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 Approximate interval Between
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20b. PLACE AND DATE of DISPOSITION OATE 20c. LOCAT Commetery, crametory or other place) Metro Crematory, Inc. 3-24-93 C Metro Crematory, Inc. 3-24-93 C 22. NAME AND ADDRESS OF FACILITY McCull 3204 Mountain Rd., Pair 3204 M	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 atory arrest, Approximate Interval Between Onset and Death
20b. PLACE AND DATE of DISPOSITION OATE 20c. LOCAT Commetery, crametory or other place) Metro Crematory, Inc. 3-24-93 C Metro Crematory, Inc. 3-24-93 C 22. NAME AND ADDRESS OF FACILITY McCull 3204 Mountain Rd., Pair 3204 M	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 atory arrest, Approximate interval Between Onset and Death Disposed Anal Able Prior To COMPLETION OF CAUSE
20a. METHOD OF DISPOSITION 1 Burlal 2XIX remettor 3 Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of completely, cremetory or other place) Metro Crematory, Inc. 3-24-93 C Metro Crematory, Inc. 3-24-93 C Metro Crematory, Inc. 3-24-93 C 22. NAME AND ADDRESS OF FACILITY McCull 3204 Mountain Rd., Pair 23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 atory arrest, Approximate interval Between Onset and Death Datopsy Leb? Application of Completion of
20a. METHOD OF DISPOSITION Burlai 2X Demention	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 Approximate interval Between Onset and Death Discourse of Completion of Completion of Cause of Coath?
20a. METHOD OF DISPOSITION Burlai 2X Demention	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 Approximate interval Between Onset and Death Discourse of Completion of Completion of Cause of Coath?
20a. METHOD OF DISPOSITION Gurdal 2X Derenation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of completely, cremetory or other place) OATE 20c. LOCAT Completely, cremetory or other place) Metro Crematory, Inc. 3-24-93 C 22. NAME AND ADDRESS OF FACILITY McCull 32.04 Mountain Rd., Pa. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (Catonsville, Md. Ly Funeral Home asadena, Md. 21122 Approximate Interval Between Onset and Death Conset and Death 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO
20a. METHOD OF DISPOSITION 1	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 Approximate Interval Between Onset and Death Conset and Death 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO
20e. METHOD OF DISPOSITION Diurial 2 (Comments) Date Catonsville, Md. Ly Funeral Home asadena, Md. 21122 Approximate Interval Between Onset and Death Conset and Death 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO	
20e. METHOD OF DISPOSITION Diurial 2 (Comments) Date Catonsville, Md. Ly Funeral Home asadena, Md. 21122 Rtory arrest, Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death LUTOPSY AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OCATH? 1 YES 2 NO	
20e. METHOD OF DISPOSITION District 2// Scremation Control Part Control Pa	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 Approximate interval Between Onset and Death Approximate interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO
20e. METHOD OF DISPOSITION District 2// Scremation Control Part Control Pa	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 Approximate interval Between Onset and Death Completion of cause of ocath? 1 yes 2 No DURY OCCURED AMALABLE PRIOR TO COMPLETION OF CAUSE OF OCATH? 1 yes 2 No
20a. METHOD OF DISPOSITION Burlal 2/Dermation 3 Ramoval from State Company, caractery or other place)	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 Approximate interval Between Onset and Death Completion of cause of ocath? 1 yes 2 No DURY OCCURED AMALABLE PRIOR TO COMPLETION OF CAUSE OF OCATH? 1 yes 2 No
20s. METINGO OF DISPOSITION 20s. DATE 20s. LOCAT 20	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 atory arrest, Approximate interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO JURY OCCURED AND AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO
20e. METHOD OF DISPOSITION Burlad 2/Cyremation 3	Catonsville, Md. Ly Funeral Home asadena, Md. 21122 atory arrest, Approximate interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO JURY OCCURED AND AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO



		REGISTRAR			CERTIF	ICATE O	F DEATH		REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last) Ji	Hyui	n		Shim		2. DATE MONTH 03	OF DEATH		/EAR	TIME OF DEATH 2013 M
		4. SOCIAL SECURITY NUMBER 218-80-7670	5. SEX (6. AGE (In yn	s. last birthday)	IF UNDER 1 YEAR		7, DATE (OF BIRTH , Day, Ybar)			ACE (State or Foreign
pino	J.R	9e. FACILITY NAME (If not institution, give st	1 M 2 ZF	2:	YRS.			10-	04-19		No. of the last	KOREA
, 3 should		4800 Berwyn House Road				96. COUNTY OF DEATH College Park Prince Georges						
es 1, 2,	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d.										
iit. Pages	DIR	MARYLAND HARI	FORD			VRE DE						INSIDE CITY LIMITS? YES 2 XNO
t permit.	RAL	10e. STREET AND NUMBER				1 3	101. ZIP CODE			10g. CITIZE	N OF WHA	T COUNTRY?
020 physician. burlal-transit	FUNERAL	2098 CHAPEL ROAL	12 WAS DECEDENT	EVFR IN U.S	ARMED	13 WAS D	21078 ECENDENT OF HISPAI	NIC OBIGIN	2 (Parally Van		S.A.	A d d dd
21215-0020 al or attending physician. for use as the burlal-tra	BY	1 🔀 Never Married 2 🗌 Married 3 🗍 Wildowed 4 🗍 Divorced	FORCES? 1 FYES, GIVE WAS	YES 2	NO	If yes,	specify Cuban, Maxica ES 2 NO Specif	in, Puerto R		OF NO.	Black, W Specify:	OKIENTAL KOREAN
or atter	ETED	15. DECEDENT'S EDUC (Specify only highest grade	completed)	16a		USUAL OCCUPATION OF MINERAL DOCUMENT		16b.	KIND OF BUS	SINESS/INDUS	TRY	
	PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		STUDI				COLL	EGE		
YLAND by the hospit be detached at once.	COMPL	17. FATHER'S NAME (First, Middle, Last) HYUN SUP SHIM			-		18. MOTHER'S NA	ME (First, M	liddle, Maiden	Sumame ¹		
MARYL retained by t 5 should be notified at	BE	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (Stree	HYE and Number or Rural	SOOK		S. William St. Company of the London	orde)	
2 5 2	5	MR. HYUN SUP SHIN	1				ROAD, HAVR			4		i
6 may stor, pa		20e. METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	oval from State			OF DISPOSITION (Name of IAL PARK	3/3 199	1 1	CATION - CH		Stata MARYLAND
ALTIM death. Page tuneral direct.	1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	T GDE	MILAVE		AND ADDRESS OF FA	1-2		DOIG	,111,	THICTLAND
	- 0 	+ R. Serry	Huki	in			COND AVE.			N BURN	ΝΙΕ,	MD 21061
in by remo		23. PART i. Enter the diseases, or cahock, or heart failure. I	omplications that of List only one cause	caused the	daath. Do r	ot enter the n	node of dying, auc	h aa card	iac or reapi	ratory arrea	ŧ,	Approximate totarvai Between
fille ion,		IMMEDIATE CAUSE (Final disease or condition	DIDDENI	1100011								Onset and Death
760, ad within omplete I, crem; event,		resulting in desth)	DIPHENH DUE TO (O		NSEQUENCE OF		10N					
OX 68760, e be executed within sician and completely vior to burial, cremat traumatic event, traumatic event,	NO NO	Sequentially list conditions, if any, leading to immediate	DUE TO (C	OR AS A COP	NSEQUENCE OF	n:						<u> </u>
ate be hysician prior t	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury						į				
S, P.O. BO death certificate attending physiental Hygiene pri	HTF.	that initiated events resulting in death) LAST	DUE TO (O	IE TO (OR AS A CONSEQUENCE OF):								
the death y the attended Mental H	- 11	PART ii Other significant condition	l									
	EDICAL	PART II. Other aignificant conditions	i contributing to a	eath but n	ot reauting i	n the underlyl	ng cauaa given in	Part I.	PERFOR	MED?	AM	RE AUTOPSY FINDINGS AILABLE PRIOR TO EMPLETION DF CAUSE
Sa Para	MED							_	1 DE YES 2	□ ₩0		DEATH?
AL REC		25. WAS CASE REFERRED TO MEDICAL										\
SICIAN: The certificate he state (SICIAN:	EXAMINER?	HOSPITAL:	ER/Outpatien	# 3 □ DOA	OTHER:	PLACE OF OEATH (Ch					
HYSICIA his certif with the	PHY	27. MANNER OF DEATH	28a. DATE OF IN (Month, Day,	JURY	28b TIM	E OF 28c. II	NJURY AT		CRIBE HOW IN	JURY OCCU	PED	
DING PHYS After this death with	B	1 Natural 5 Pending 2 Accident Investigation	Found: 3		3 7:50	P M 1	YES 2 NO		JECTED			DRUGS
TTEN TOR	즲	3 Suicide a Could not be 4 Homicide determined	Residen	c. (Specny)				City o	TION (Street a r Town, State)			·
	COMPLETED	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of m					00			rryio	. II Q
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: It	8	2 MEDICAL EXAMINER		mination and	I/or investigatio	n, in my opinion,	death occured at the	1ime, date	end place, and	d due to the o	ause(a) an	d manner as stated,
TO THE HOSPITA TO THE FUNERA DE filed within 7. IMPORTANT: I	8	200 SIDNATURE AND TITLE OF CERTIFIER	icho	MA			29c. LICENSE NUM					onth, Day, Year)
₽₽3.	2	MAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH	(ITEM 27) (Type,	Print)	I O.C.M.	E		03	29	1993
-		J. Laron Locke.	MD.	11		nn Str	eet, Bal	Ltimo	ore,	Mary.	and	21201
		MAR 3 0 1993		- AS-	Parletto							

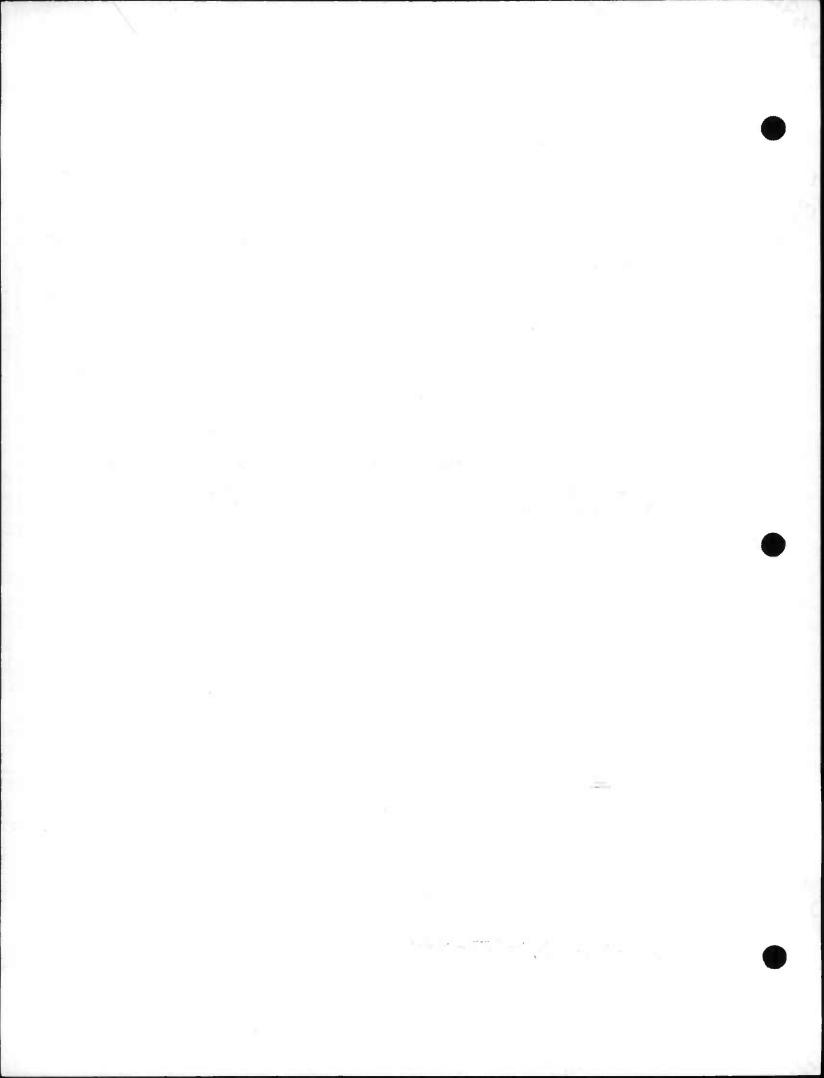
	an.	transit permit. Pages 1.2.3 should			
SALIMORE, MANIENDE SIZES OF STATE OF STATE SIZES OF	VYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	Ill sertificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should		notified at once.	
שמרווווסורי,	n 24 hours after death. Page 6 may be	ly filled in by the funeral director, page	ation, or removal.	id, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
, co. co. co. co.	the death certificate be executed within	the attending physician and completel	the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	njury, or other traumatic event,	
	NG PHYSICIAN: The law requires that t	ther this certificate has been signed by	daily with the State Dept. of Health and	marked, or item 23 shows any i	
	TO THE HOSTING OR WITHOUT	TO THE FLINERAL DISCLOS. A	be filed within 72 hours after d	IMPORTANT: If item 28 is	

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTMEN CERTIFICAT	IT OF HEALTH A	ND MENTA	AL HYGIENE REG. NO.		00370
	1. DECEDENT'S NAME (First, Middle, Lest) Szmago LSKy	John			2. DATE MONT	of DEATH	93 YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 215-12-5007	1 M 2 □ F	7 YRS. MONTH	DAYS HOURS	HRS. 7. DATE	of BIRTH th. Day, Year) 31-22	A. BIRTH	PLACE (State or Foreign
TOR	96. FACILITY NAME (If not institution, give stri VA MD GREENE S RESIDENCE OF DECEDENT	STREET	9b. Cf	BALTIMOR		9c, C	COUNTY OF DI	EATH
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND		10c. CITY, TOWN	OR LOCATION TIMORE				10d, INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	104. STREET AND NUMBER 2065 EASTERN AV	VENUE		101. ZIP CODE 2 1 2 2	24	10g.	THAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS OECEDENT EVER IN U.S FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES WWII	□NO				14. RACE Black	— American Indian, White, etc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION 16a completed) College (1-4 or 5+)	OECEDENT'S USUAL (Give kind of work don life. Do NOT use retired DISABLE	during most of working	161	b. KIND OF BUSINESS	•	
BE CON	17. FATHER'S NAME (First, Middle, Lest)			18. MOTHER	R'S NAME (First,	Middle, Melden Sumam	10)	
TO B	190. INFORMANT'S NAME (Type/Print) MRS. ROSEMARY SZ	ZMAGALSKI	196. MAILING ADORE SAME	SS (Street and Number or	Rural Route Num	nber, City or Town, State,	Zip Code)	
	20a METHOD OF DISPOSITION 1 A Buriel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	rel from State 20b. PLA	CEAND DATE OF DISPO	SITION (Name of	0A1 3-	1100	- City or Ton	
	21. SIGNATURE OF FUNERAL SERVICE LICE	Sparons	W)	NAME AND ADDRESS CACZOROWS 2525 FLEE	T ST.	BALTO.	MD.	21224
CERTIFICATION	23. PART I Enty the diseases, or constant, or heert fellura. Li IMMEDIATE CAUSE (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	PRELIMANI DUE TO (OR AS A CON COPD DUE TO (OR AS A CON COMPANA	OL NSEQUENCE OF):			unit of feathratory	arrest,	Approximate Interval Between Onset and Death
ERTIF	that initiated events resulting in desth) LAST	DUE TO (OR AS A COM	NSEQUENCE OF):			4.3		
PHYSICIAN: MEDICAL C	PART II. Other algnificant conditions	contributing to death but n	of resulting in the u	inderlying cause give	en in Part I.	24a. WAS AN AUTOP PERFORMED? 1 YES 2 NO		WERE AUTOPSY FINDINGS MANILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 TYPES 2 NO	HOSPITAL:	R 3 DOA 4 N	26. PLACE OF OEAT				
	27. MANNER OF OEATH 1. Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DE:	SCRIBE HOW INJURY	OCCUREO	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be datermined	28e. PLACE OF INJURY — A building, etc. (Specify)	At home, farm, street, factory, office			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
COMPLETED		use(e) end menner as e end place, and due to		end menner se stated.				
BE	296. SIGNATURE AND FITLE OF CERTIFIER	elamo		29c. LICENS	E NUMBER	29d, C	3//	(Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WHO	_ 205.6	reen s	1. Balt	mp	21201	1	-20,
	31. DATE FILED (MONTH, Day, Year) MAR 3 0 1993	32. REGISTRAR'S SIGNATUR	delle.					0,0



ITEMS: 23 PART I, 27, 28b,d,f, PER MEO G-698 4/9/93 t.t 93 08571

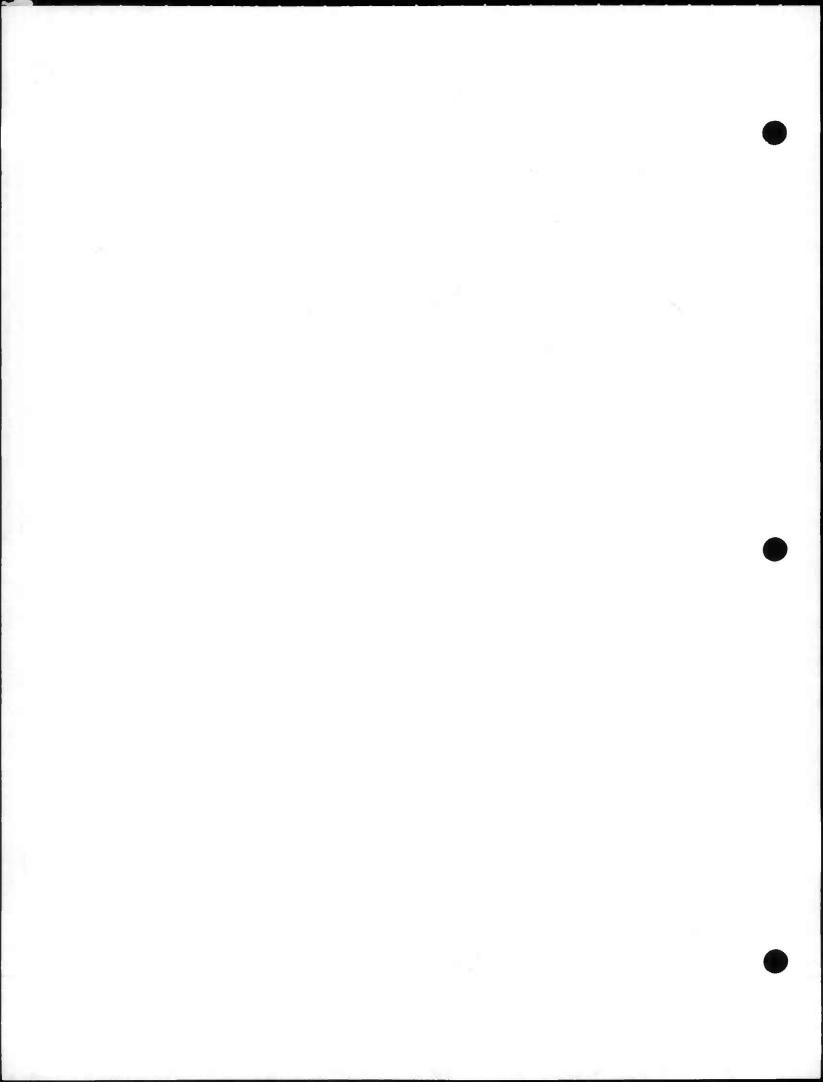
200 72 4437 1X w 27 1X w 27 33 vrs. 3. ADE (in yrs. the tomology 1 vrs. 10 comes 1 vrs. 10		1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	IEALTH AND I	MENTAL HYGIEN			
4 SOURCE SECURITY NAME (or anathonic per time of conditions) 10 STORY 2 4437 10 STORY 17 1960 10 Many 1 10 STORY OR ALL COUNTY 10 STORY OR ALL COUNTY 11 STORY OR ALL COUNTY 11 STORY OR ALL COUNTY 12 STORY OR ALL COUNTY 13 STORY OR ALL COUNTY 14 STORY OR ALL COUNTY 15 STORY OR ALL COUNTY 16 STORY OR ALL COUNTY 17 STORY OR ALL COUNTY 18 STORY OR ALL COUNTY 19 STORY OR ALL COU					SEI	TDD JR	MONTH DA	V QYEAR	3. TIME OF DEAT	тн Ам
BALT MORE ANNAPOLIS BLVD Glen Burnie ANNE ARUNDEL MATYLAND MATYLAND Anne Arundel MATYLAND		4. SOCIAL SECURITY NUMBER 220 72 4437	5. SEX 6. AGE (In		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	B. Bif	RTHPLACE (State or Fountry)	oreign
MATYLAND Anne Arundel Pasadena September September	TOR	BALTIMORE & AN					АТН			
T. MANDERS, STATUS Manufact 1 manufact	E	Maryland Ann		10c. CITY,	TOWN OR LOCAT		ena		LIMITS?	
DOUBLE WOOD OF DISCREPANCE (Fine Indicated expending) in Care Signature (September 1997) in Care Signature (September 199	NERAL	656 209th St.			101		22	1000		
Sequentially list conditions	BY	1 Never Married 2 Married	FORCES? 1 TYES	2 XNO	If yes, sp	ecify Cuban, Maxica	n, Puerto Rican, etc.)	Bi	lack, White, atc.	
PAUL L. Seipp, Sr. 1769 Invermess Rd., Baltimore, MD 21222 20. PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24. WAS AN AUTOPEY PERFORMENT OF COMPLEX BROWN OF CAUSE (Pined Idease or condition resulting in death) LST (Post and Part II) Indentified events resulting in death) LST (Post and Part II) Indentified events resulting in death) LST (Post and Part II) Indentified events resulting in death) LST (Post and Part II) Indentified events resulting in death) LST (Post and Part II) Indentified events resulting in death) LST (Post and Part II) Indentified events resulting in death) LST (Post and Part III) Indentified events resulting in death) LS	LETED	(Specify only highest gra-	de completed)	(Give kind of wo	rk done during mo retired.)	ON st of working	10000000			
Paul L. Seipp, Sr. 1769 Invermess Rd., Baltimore, MD 21222 20. METHOD OF DISPOSITION 17 Beams of Pure Round Number, City or Num. Shin, Zip Code) 17 Bould 2 Commention 3 Removal from State Control 17 Bound 2 Commention 3 Removal from State Control 17 Bound 2 Commention 3 Removal from State Control 17 Bound 2 Commention 3 Removal from State Control 17 Bound 2 Commention 3 Removal from State Control 17 Bound 2 Commention 3 Removal from State Control 17 Bound 2 Commention 3 Removal from State Control 18 Bound 2 Commention 3 Removal from State Control 18 Bound	SOME			Lar	orer	18. MOTHER'S NAI			tillery	_
PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 204 NES AND TO THERE COURSE (Please or Injury that indited events resulting in death) **S. WAS CASE REFERRED TO MEDICAL SCHOOL AND TO THE STREET COURSE (Please or Injury that indited events resulting in death) **DUE TO (OR AS A CONSCOURNCE OF): **S. WAS CASE REFERRED TO MEDICAL SCHOOL AND THE STREET COURSE (Please or Injury that indited events resulting in death) **DUE TO (OR AS A CONSCOURNCE OF): **S. WAS CASE REFERRED TO MEDICAL SCHOOL AND THE STREET COURSE (Please or Injury that indited events resulting in death) **DUE TO (OR AS A CONSCOURNCE OF): **S. WAS CASE REFERRED TO MEDICAL SCHOOL AND THE STREET COURSE (Please or Injury that indited events resulting in death) **PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24 Nes AN AUTOPET PROPRIET CONFIDENCE OF): **S. WAS CASE REFERRED TO MEDICAL SCHOOL AND THE STREET COURSE (Please or Injury that indited events resulting in death) **PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24 Nes AN AUTOPET PROPRIET CONFIDENCE OF): **S. WAS CASE REFERRED TO MEDICAL SCHOOL AND THE STREET COURSE (Please or Injury that indited events resulting in death) **PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24 Nes AN AUTOPET PROPRIETY FROM TO AUTOPET PROPRIET										
The Notice of the Part I. See the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart feiture. List only one cause on each line. 22. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart feiture. List only one cause on each line. 32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, interval Batween Onest and Dast disease or condition. 32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, interval Batween Onest and Dast disease or condition. 32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat. 32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat. 32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat. 32. PART II. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat. 32. PART II. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat. 32. PART II. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat. 32. PART II. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat. 32. PART II. Enter the disease or conditions. 32. PART II. Enter the diseases. Or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat. 32. PART II. Enter the disea										
21. SIGNATULE OF FINERAL SERVICE LICENSES 22. NAME AND ADDRESS OF MICLITY MCCULTY Futher all Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122		20a. METHOD OF DISPOSITION	20b. P	PLACE AND DATE OF	DISPOSITION /Na					
22. PART I. Enfet the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart feiture. List only one ceuse on each line. IMMEDIATE CAUSE (Finel diseases or condition as a treat refuture. List only one ceuse on each line. IMMEDIATE CAUSE (Finel diseases or condition as a treat refuture. List only one ceuse on each line. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions. If any, leading to immediate cause. Enter UNDERLING Cause or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Cause (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Cause (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Cause (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Cause (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Cause (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Cause (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PRICING OF CAUSE CONSEQUENCE OF): Cause (Disease or injury that initiated events resulting in the underlying cause given in Part I. 25. WAS CASE REFERRED TO MEDICAL EXAMINED TO MEDICAL EXAMINED TO PROPERTY IN TO P		4 Donation 5 Other (Specify)	Gle	tery, crematory or othe	Memoria	al Park 3	1			
22. PART I. Entite the diseases, or bomplications that ceused the death. Do not enter the mode of dying, such as cardiac or reapiratory arreat, abock, or heart feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury in death) LAST DUE TO (OR AS A CONSEQUENCE OF): 25. WAS CASE REFERENCE TO MEDICAL EXAMINER? 1 Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. WAS CASE REFERENCE TO MEDICAL EXAMINER? 1 OTHER: 1 OTHERS: 2 ON DISTANCE OF DEATH (Check only one) 2 AMERICAN OF DEATH 1 OTHERS: 2 OTH		21. SIGNATURE OF FUNERAL SERVICE I	Herrum		McCu1	ly Funer	al Home of	Pasade	na	2
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETEND AS AN AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETEND TO COMPLETEND TO COMPLETEND TO COMPLETE A COMPLETEND TO COMPLETE A COMPLETEND TO COMPLETE AND THE PRIOR TO COMPLETE AND THE PRIOR TO COMPLETE AND THE PRIOR TO COMPLETE AND THE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETE A COMPLETE AND THE PRIOR TO COMPLETE AND THE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETE AND THE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETE AND THE PRIOR TO COMPLETE AND TH		iMMEDIATE CAUSE (Fine) disease or condition	a. HEAD AND EXT	TREMITY I			h as cardiac or reapi	ratory arreat,	Interval B	atween
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETEND AS ANALABLE PRIOR TO COMPLETE ANALABLE PRIOR TO COMPLETE ANALABLE PRIOR TO COMPLETE PRIOR TO COMPLETE ANALABLE PRIOR TO COMPLETE PRIOR TO COMPLETE ANALABLE PRIOR TO COMPLETE ANALABLE PRIOR TO COMPLETE PRIOR TO COMP	ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	c							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 NO	AL	PART II. Other significant condition	ns contributing to death but	t npt reaulting in	the underlying	g cause given in i	PERFOR	MED?	AVAILABLE PRIOR COMPLETION DF C OF DEATH?	TO
2 Accident 3 - 26 - 1993 5 - 15	SICIAN:	EXAMINER?		New 2 Do	THER.					
3 Sulcide 4 Homicide 5 Microst and Number or Burst Noute Number of City or Town, State) Anne Arunder Co. Md 29a. CERTIFUNG Physician: To the best of my knowledge, death occurred at the time, date end piace, and dua to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFURE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED AUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 2120		27. MANNER OF DEATH 1 Netural Pending	FO WWW.Dex; Year) 3-26-1993	FOUN 5 15	DM 28c. INJ	URY AT RK? 'ES 2 XNO	28d. DESCRIBE HOW IP			
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 3-26-1993 111 Penn Street, Baltimore, Maryland 2120	ED	4 Homicide determined			ON LA	WN	BALTIMORE	Anne Aru E & ANN	undel Co.	Md. BLV
29c. LICENSE NUMBER 29d. DATE SIGNED (Morith, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED KAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 2120	COMPL	(Check only one) CENTIFYING PHY	IER: On the basis of examination a						e(a) and menner as st	tated.
111 Penn Street, Baltimore, Maryland 2120	BE	Den	m 2Ch	ut				•		
				111 Pe		reet, Ba	altimore,	Mary	land 21	201



spring attending physician.	use as the burial-transit permit. Pages 1, 2, 3 should			
TO THE MOST INC. OF ALL MOTING PRINCIPLY. THE TOWN EQUILED HEAD OF ENGLISH WHITE AT HOURS ALICE DEBUT. FOR DIRECT PRINCIPLY AND THE PRINCI	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be outselved in use as the burial-transit permit. Pages 1, 2, 3 sh	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified an examination of the contract o	

BALTIMORE, MARYLAND 21215-0020

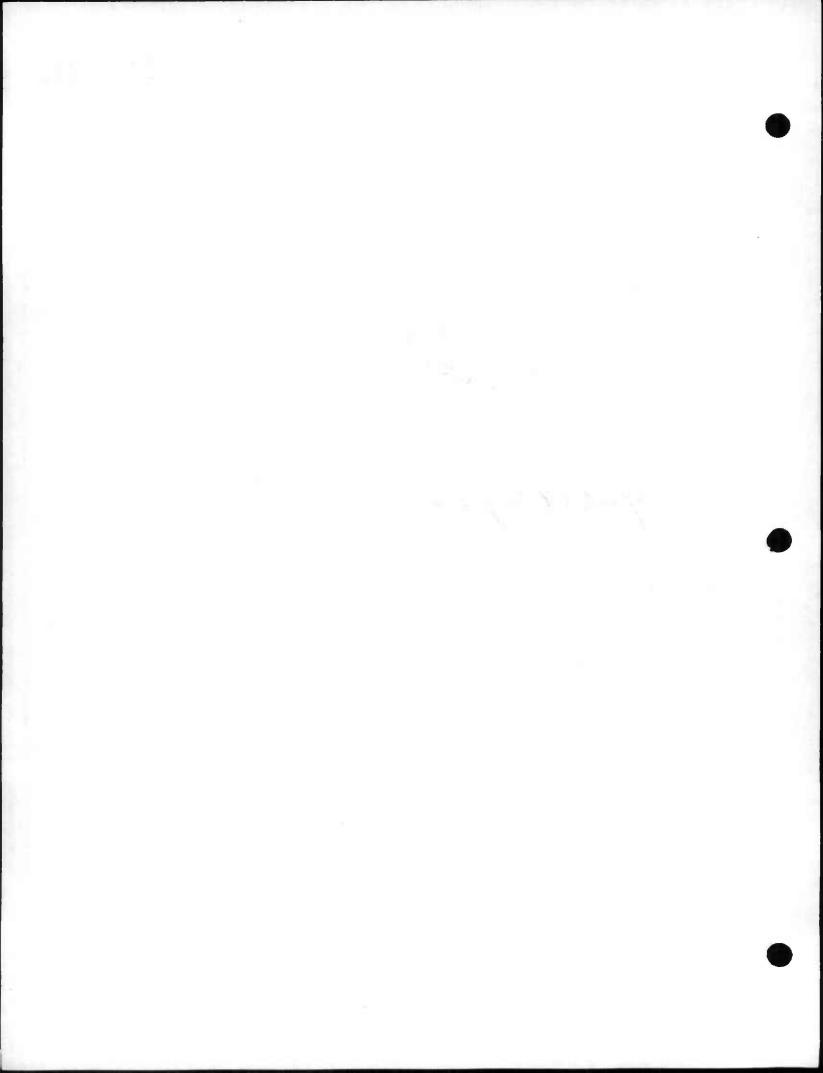
	W-10							-36-		93 08572	
1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	DECEDENT'S NAME (First, Middle, Last) TYLER HAYWO	OD SMITH						RCH 26	1993	3. TIME OF DEATH 10:00 PM	
DIRECTOR	4. SOCIAL SECURITY NUMBER 5	i. SEX 6. AGE (In yrs. las	t birthday)	IF UNDE	R 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DAT	E OF BIRTH rith, Day, Year)	161	B. BIRTHPLACE (State or Foreign Country)	
	9a. FACILITY NAME (If not institution, give stree	9a. FACILITY NAME (If not institution, give street and number)				R LOCATION OF D					
	THE JOHNS HOPKINS HOSPITAL BALTIMORE						Υ		BAL	TIMORE	
	N. J. MOMOUTH			10c. CITY, TOWN OR LOCATION MATAWAN				10d. INSIDE CITY LIMITS? 1 M YES 2 NO			
FUNERAL	100. STREET AND NUMBER 13 HOMESTEAD DR.			101. ZIP CODE 07747					N.F.C.	ZEN OF WHAT COUNTRY?	
BY FUNE	11. MARITAL STATUS 1. MAS OECEDENT EVER IN U.S. ARME 1. Mas OECEDENT EVER IN U.S. ARME FORCES? 1 VES 2 MON IF YES, GIVE WAR OR DATES			13.	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Verify yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 (NO Specify:						
	(Specify only highest grade completed) (Give kind of work done during most of working						Sb. KIND OF BUS	INESS/IND			
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+) O INFANT										
	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S N.	NAME (First, Middle, Melden Surname)				
B							RAREED al Route Number, City or Town, State, Zip Code)				
의	WILLIAMS FUNERAL HOME 5628 BROADWAY 232 ST. BRONX, N.Y. 10463.										
	20a. METHOD OF DISPOSITION 1										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										
	William Lava III				HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO.,MD. 21212.						
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final										
	disease or condition - a. Brain death 2 IVH (intraventicular henumbary 8/25/93)										
NO	DUE TO (OR AS A CONSEQUENCE OF): MULTI SUSTEM CYCLO PULLUE 13/18/193										
_	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING										
CERTIFICAT	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST										
	d										
MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE									AMAILABLE PRIOR TO COMPLETION OF CAUSE	
ME	0 F DEATH? 1 YES 2 NO										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? ALCOHOLOGY ALCOHOLOGY 26. PLACE OF OEATH (Check only one)										
IYSI	1 TES 2 NO 1	HOSPITAL: 1 Vinpstient 2 ER/Outpstient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									
BY PH	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation		28b. TIMI INJ	E OF URY M	28c. INJURY AT WORK?		28d, O	28d, DESCRIBE HOW INJURY OCCURED			
	3 Suicide 6 Could not be determined 26a. PLACE OF INJURY — At home, farm, street, factory, office 26b. LOCATION (Street and Number or Rural Route Number, City or Town, State)								or Rural Route Number,		
COMPLETED	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. Communication and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.										
ပ္ပ	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)										
10 B	1 /K (7 Mp				D43054 >				> (3/26/93	
-	A / 1/ 1/2	O. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (TYPO, PTINI) ARRYL R. PUNN TERC CHAPER CUE DR. LAURER MO 25757									
31. DATE FAMOLYMOND, Day, YEAR, 3 0 1993 Julia Saidson-Randalle											



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frouts after death. Page 6 may he renained by it
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be entanted to be burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Bed, of Health and Mental Hydiene prior to burial cremation or removal
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	EALTH AND	MENTAL HYGIEN		00070	
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF OEATH 3. TIME		
	Virginia L.	Swieczkow				3 27	198	6;00A m	
		5. SEX 6. AGE (III	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		IRTHPLACE (State or Foreign country)	
	9a. FACILITY NAME (If not institution, give stre	2.2	58 YRS.			(Month, Day, Year) 2 21 1		ston W. Va.	
DIRECTOR	Fifth Ave. 691				Lk Ave.		9c. COUNTY Balti		
E C	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY	
	Maryland Balti:	more	Dunc		LIMITS? 1 YES 2X 101. ZIP CODE 100. CITIZEN OF WHAT COUNTRY?				
FUNERAL	Fifth Ave. 6910			100	21222			States	
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Ye		RACE — American Indian, Black, White, atc.	
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES		If yes, spi	Cify Cuban, Maxic	an, Puarto Rican, atc.)		Bleck, White, atc.	
	15. DECEDENT'S EDUCA	TION		1				White	
E	(Specify only highest grade co	impleted)	16a. DECEDENT'S U (Give kind of wo life. Do NOT use	vrk done during mo:	N st of working	16b. KIND OF BU	SINESS/INDUST	RY	
P	12	College (1-4 or 5+)	House W	life		Dome	stic		
COMPLETED	17. FATHER'S NAME (First, Middle, Last) Frank Gi	um			18. MOTHER'S N	AME (First, Nigdle, Majdee Hawk I			
BE (Grace	nawki	.115		
0	19a. INFORMANT'S NAME (Type/Print) Chester Sw	ieczkowski	19b. MAILING A	DDRESS (Street a	nd Number or Rural	Route Number, City or Tow	n, State, Zip Code	9)	
	5					undalk,			
	20a_METHOD OF DISPOSITION 1	al from State 20b.I	LACE AND DATE OF	DISPOSITION (Na	ne of	3/30 Dui	CATION — City	or Town, State	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	INC.	TY CIUS	22. NAME AN	D ADDRESS OF F	b/ 30 Dai	idaik,	Ma.	
	· Mark C	1 (1	0	W. Dab	rowski	7Chojnacl	ki F.H	. P.A.	
	23. PART I, enter the diseases, or cor	nolications that caused	the death. Do no	11002	Dundal	K Ave. Ba	alto.,	Md. 21224	
	Ahock, or heart feilure. Lie IMMEDIATE CAUSE (Final	at only oge ceuse on ee	en une.			m as cerdiec or reep	ratory erreat,	Approximate interval Between	
	disease or condition resulting in death)	Myoca	ulul	inta	cteau.			Onset and Death	
	resulting in death) / a	DUE TO (OR AS-A	CONSEQUENCE OF						
N	Sequentially list conditions, b.		uc trai						
ATI	if any, leeding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A C	ONSEQUENCE OF:	alla	wood	20.0			
EI	CAUSE (Diseese or injury that initiated events	DUE TO (OR AS A C	()		040-30004	I KW			
CERTIFICATION	reaulting in death) LAST	reup	I foul	me					
CAL	1	and well star	not resulting in	the underlying	cause given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
MEDIC		typuteuson	11000000			1 TYES 2	MO	OF DEATH?	
Σ :		30110-00-03	0.000000			-	1	1 TYES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PL	ACE OF DEATH (Ch	eck only one)			
SIG		OSPITAL: inpatiant 2 in ER/Output		OTHER:	5 Residenca	6 Other (Specify)			
PH	27. MANNER OF DEATN 1 P Netural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME	OF 28c. INJU	RY AT	26d. DESCRIBE NOW I	NJURY OCCURE	,	
В	2 Accident Investigation			M 1 🗆 Y	ES 2 NO				
	3 Suicida 6 Could not be datarmined	26a. PLACE OF INJURY — building, atc. (Specify	- At home, tarm, atro	eet, factory, offica		261. LOCATION (Street a City or Town, State)	and Number or Ru	rel Route Number,	
COMPLETED	29a. CERTIFIER								
MP	(Check only CERTIFYING PHYSICIA (Check only one) 2 MEDICAL EXAMINER:	N: To the best of my knowled	ige, death occurred	at the time, date a	and place, and due	to the cause(a) and mar	iner as stated,		
	29b. SIGNATURE AND THE OF CERTIFIER			in my opinion, de					
BE	THEFILL				29c. LICENSE NUI		29d. DATE SIG	NED (Month, Day, Year)	
임	30. NAME AND ADDRESS OF PERSON WHO C		N (ITEM 27) (Type, P	rint)		~ .0	,	, , , , , ,	
	Kennell		almour						
ļ	Lander a . Cal.	. ~							



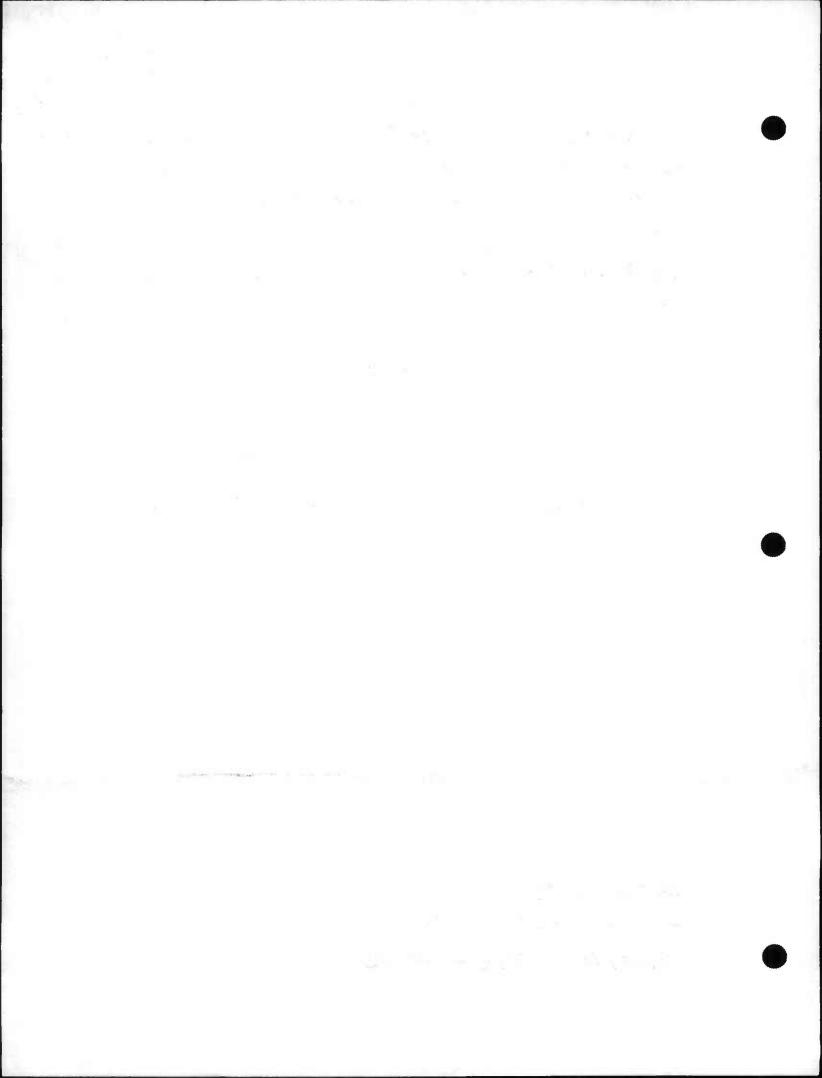
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or and official physician.

TO THE RUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

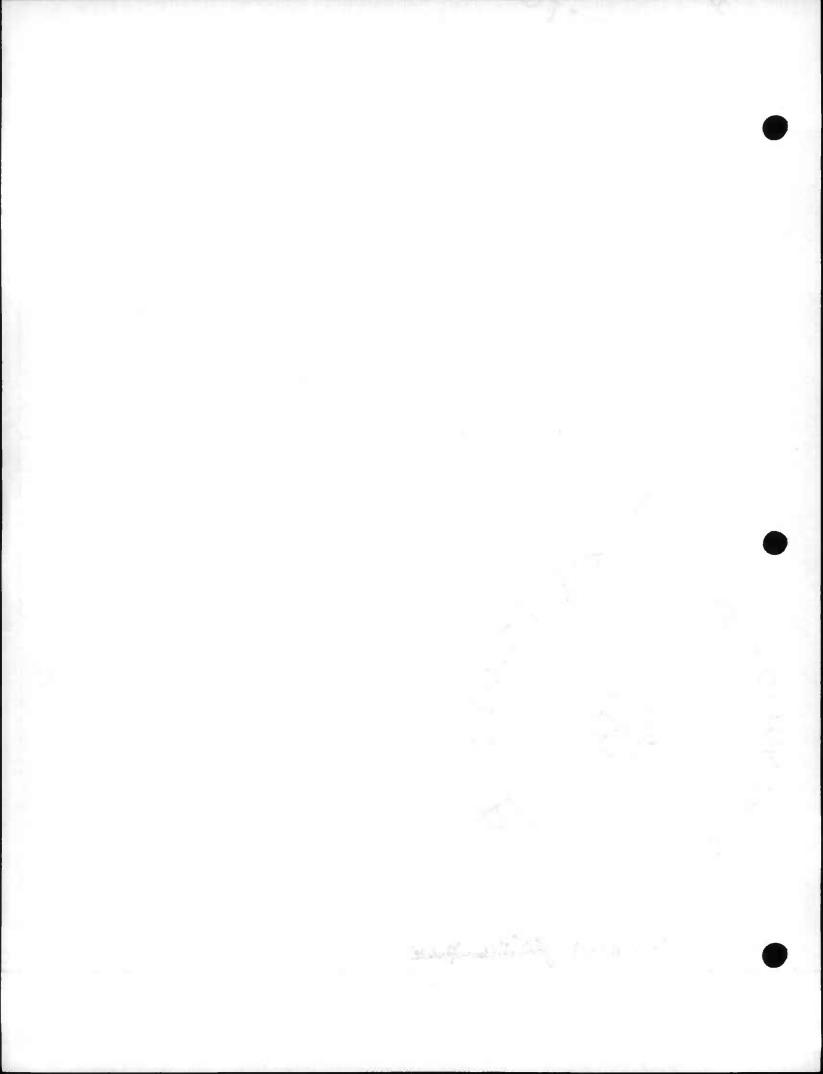
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

				93/16	8574				
	1 - FOR STATE OF MARYLAND / DEPARTMENT CERTIFICATION	T OF HEALTH AND E OF DEATH	MENTAL HYGIEÑE REG. NO.	93.	08574				
10	MAIALLUE SIELN	EIN	2. DATE OF OEATH DAY	YEAR	3. TIME OF GEATH				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdey) F UNDER WONTHS WONTHS	R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year)	3 8. BIRTHP Country)	LACE (State or Foreign GERMANY				
DIRECTOR	96. FACILITY NAME (If not institution, give street and number) SINAI HOSPI TAL RESIDENCE OF DECEDENT	RALTI/	MORE	9c. COUNTY OF DE	ATH				
	100. STATE 10b. COUNTY BOLL 10c. CITY, TOWN O	Ba	1+0		10d. INSIDE CITY LIMITS? 1ES 2 NO				
FUNERAL	10. STORET AND NUMBER 47.02 Deld Left 11. MARITAL STATUS 12. MAS DECEDENT EVER IN U.S. ADMED 13. MAS DECEDENT EVER IN U.S. ADMED 14. MAS DECEDENT EVER IN U.S. ADMED 15. MAS DECEDENT EVER IN U.S. ADMED 16. MAS DECEDENT EVER IN U.S. ADMED 17. MAS DECEDENT EVER IN U.S. ADMED 17. MAS DECEDENT EVER IN U.S. ADMED 18. MAS DECEDENT EVER IN U.S. ADMED 19. MAS DECEDENT EVER IN	101. ZIP CODE	208	U51	AT COUNTRY?				
B	in the state of th	WAS DECENDENT OF HISPAI If yea, specify Cuben, Maxica 1 YES 2 23 NO Specifi	NIC ORIGIN? (Specify Yes on, Puerto Rican, etc.) y:	or No— 14. RACE Black, Specify	American andlen, white, etc.				
LETED	15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12. 15. DECEDENT'S USUAL O (Give kind of work done life. Do NOT use retired.)	CCUPATION during most of working	16b. KIND OF BUSH	NESS/INDUSTRY	₹				
E COMPLET	17. FATHER'S NAME (First, Middle, Lest) EMIL HARF	18. MOTHER'S NA	HOME ME (First, Middle, Maiden St DUISE DRUC		<u> </u>				
TO BE		S (Street and Number or Rural I			D.(21136)				
	20a, METHOD OF DISPOSITION 1 X Burlet 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)	S CHESED 3,		ATION — City or Tow DALLSTOWN					
	Day A Sami	NAME AND ADDRESS OF FA SOL LEVINSON SOLO REISTERS	& BROS. FU	NERAL HO	ME, INC.				
	23. PART Enter the diseases, or complications that caused the desth. Do not enter shock, or heart feiture. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):	the mode of dying, suc	th as cerdisc or respire	attro-intory errest,	Approximate interval Between Onset and Death				
EKILLICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):								
THE SIGNAL MEDICAL O	PART ii. Other significent conditions contributing to deeth but not resulting in the un	ED?	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO						
יונייייי	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO OTHER NO OTHER								
	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY (Month, Day, Year)	28c. INJURY AT WORK?	8 U Other (Specify) 28d. DE\$CRIBE HOW INJ	URY OCCURED					
IED BY	2 Accident Investigation 3 Suicide 8 Could not be detarmined								
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the tild one) 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my of				and manner as stated.				
O BE C	296. SIGNATURE AND TITLE OF CERTIFIER AND LEAVEN MD	29c. LICENSE NUM		29d. DATE SIGNED (A					
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) A H G VAR INO, MD								
	31. DATE FILED (MONTH, Day, Year) 32. REGISTRAR'S SIGNATURE MAR 3 0 1993 Guha Landon Hander								



FOR

		1 - STATE ROBERT G. STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.						
	1	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3/28/93 WONTH 3. TIME OF DEATN						
♥.		Robert SHEPPARD Harch 28 1993 9:45 A						
29	ó	4. SOCIAL SECURITY NUMBER 5. SEX 212-12-2676 6. AGE (In yrs. liest birthday) F UNDER 1 YEAR F UNDER 24 HRS. NONTHE DAYS HOURS MIN. 7. DATE OF BIRTH (Month, Day, Year) JULY 27, 1904 RARYLAND						
should		9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH						
1, 2, 3	DIRECTOR	FRANKLIN SQUARE HOSPITAL ROSEDALE Baltimore County						
iges 1	REC	19a. STATE 10b. COUNTY 19c. CITY, TOWN OR LOCATION 10d. INSIDE CITY						
permit. Pages		MARYLAND BALTIMORE ESSEX 1 ves 2 No						
	RAL	104. STREET AND NUMBER 107. ZIP CODE 109. CITIZEN OF WHAT COUNTRY?						
020 physician. burial-transit	FUNER	6600 RIDGE ROAD 21237 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Ves or No						
-0020 Jing physician the burial-tra	BY	11. MARTIAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Yes apecity Cuben, Mexican, Puerto Rican, etc.) 1 Yes, apecity Cuben, Mexican, Puerto Rican, etc.)						
ND 21215-0020 hospital or attending physic ached for use as the burial ce.	PLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) CoRege (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 17b. KIND OF BUSINESS/INDUSTRY						
YLA by the be det	BE COMP	17. FATHER'S NAME (First, Middle, Last) EDWIN THOMAS SHEPPARD 18. MOTHER'S NAME (First, Middle, Makden Surname) MARY GRACE HENRY						
MAR retained to 5 should notified	TO B	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)						
	-	REV. CHARLES E. MORGAN (FRIEND) 211 RUSSELL AVENUE, SUITE 109, GAITHERSBURG, MD. 200						
ALTIMORE, leath. Page 6 may be funeral director, page		20b. PLACE AND DATE OF DISPOSITION Name of Compatition 3 Grandows from State 4 Donastion 6 Other (Specify) BALTIMORE, MARYLAND						
ALTIMO death. Page 6 funeral direct examiner mu		21. SIGNATURE OF FUHERAL SERVICE LICENSES. 22. NAME AND ADDRESS OF FACILITY						
BALTIMORE, ter death. Page 6 may be the funeral director, page val.		LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD.21228						
68760, BALTIN secuted within 24 hours after death. Pag and completely filled in by the funeral dir burial, cremation, or removal. attic event, the medicel examiner		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Acute Respiratory Failure secondary to hypovolemic one to him to him the property of the provided interval Between Onset and Death of the provided interval Be						
P.O. BOX 68 In certificate be execunding physician and Hyglene prior to bur or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr injury that initiated events resulting in death) LAST Dehydration secondary to hypovolemia but to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.							
Me de d	AL C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS						
VITAL RECORI JAN: The law requires that the rifficate has been signed by the Extate Dept. of Health and or Item 23 shows any In	MEDICA	PERFORMED? AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO 1 YES 2 NO						
law ra law ra las bec Dept. c								
N: The law icate has be State Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO						
Tree Ce	PHY	27. MANNER OF DEATN 286. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 Notural 5 Pending 28c. INJURY AT WORK? M 1 VES 2 NO						
DIVISION OF OR ATENDAS PRISIC DIRECTOR And the ca hours after death with the	TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Nomicide determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
S S S S S S S S S S S S S S S S S S S	COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner as stated. MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end menner se stated.						
TO THE HOSPITAL (TO THE FUNERAL (De filed within 72 h IMPORTANT: If II	BE	296. SIGNATURE AND SIPLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Your) March 28, 1993						
	2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)						
41	}	Louis Ortega, M.D. 9000 Franklin Square Drive Baltimore MD 21237 31. DATE FILED (Month, Day, War) 32. MEGISTRAR'S SIGNATURE						
		31. Date FileD (Month, Day, War) MAR 3 0 1993 St. MEGISTRAR'S SIGNATURE And St. Medistriction Anglese						



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	0	ä	Š	ē
_	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 h	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation,	=
		S	~	-
	S	씾	듄	STANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the r
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	BALTIMORE, MARYLAND 2,1215,0020	
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours	he law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or-enging physician.	
DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for undersome the burial-transit norms 1.2.3 should	
hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	emoval.	
item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	dical examiner must be notified at once	

93 08576 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH MONTH 123 YEAR STEIN ALBERT 993 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. lest birthdev) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (Sta Country) 1 1 2 E DAYS HOURS 215-10-4621 YRS. 86 MARYLAND 1-19-1907 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWH OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 6632 EBERLE DR., APT. BALTIMORE 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND BALTIMORE YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6632 EBERLE DR., APT. 303 21215 USA 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 VANO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, atc. If yes, specify Cuban, Mexicen, Puerto Rican, etc.)

1 Yes 2 Tho Specify: 1 Never Married 2 Merried BY Specify: WHITE 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EOUCATION pecify only highest grade complete 16a. DECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) **EDUCATION** 4 TEACHER 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) REBECCA MEYER STEIN (UNKNOWN) BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 6632 EBERLE DR., APT. 303 BALTO., MD MRS. CELIA STEIN 21215 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other piece) 3-28-93 OATE 20c. LOCATION - City or Town, State MOSES MONTEFIORE WOODMOOR HEBREW BALTIMORE, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215 23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or reepiratory arrest, shock, or heert fellure. List only one cause on each line. **Approximata** interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) AHEAUSCENETIC CAMIQUASCUM NIS
DUE TO (OR AS A CONSEQUENCE OF): 4 Dec MEDICAL CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE INUSCUTIONE DEPLES 1 TES 2 NO DF DEATH? BurrunA PNN.CIMES 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Residence 8 Other (Specify) 4 - Nursing He 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY WORK? 28d. OEŞCRIBE HOW INJURY OCCURED Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Yown, State) COMPLETED 8 Could not be determined 4 Homicide CERTIFIER (Check only Cone) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. 29a. CERTIFIER 2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CENTURER ATSTAM BE 29d. DATE SIGNEO (Month, Day, Year) Pity 568 15 2

HEIGHT AVE.

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32 MEGISTRAB'S SIGNATURE

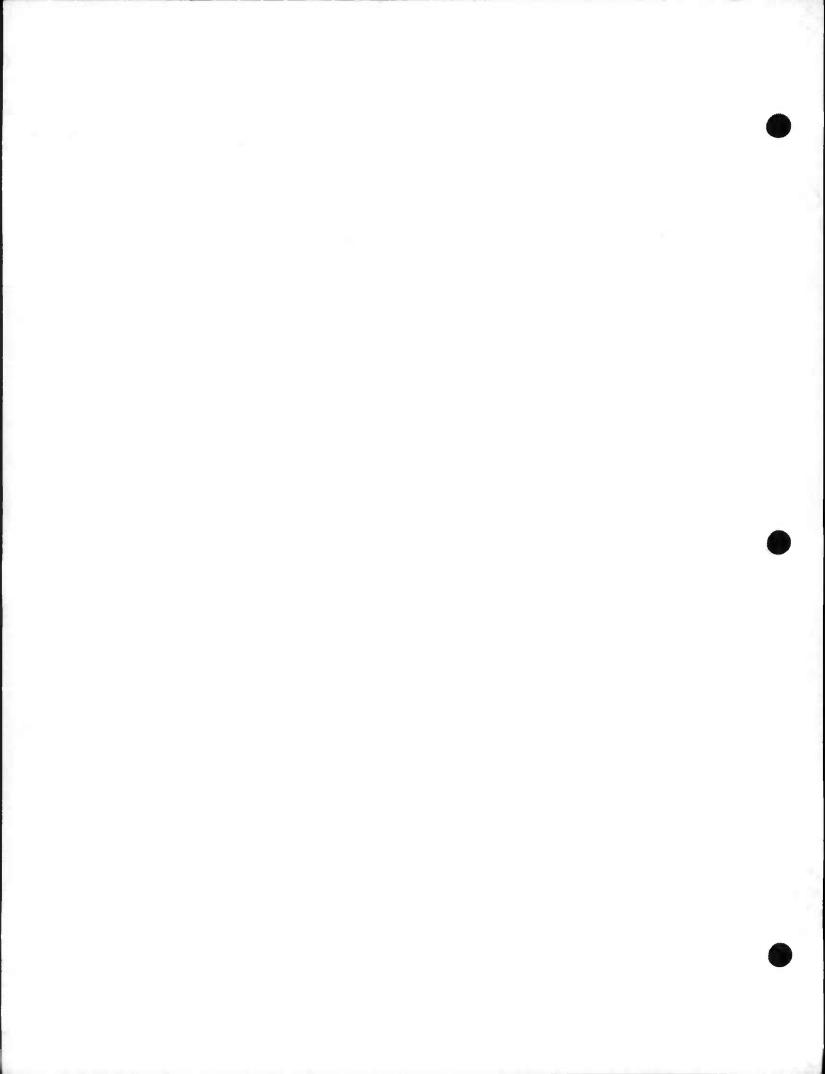
TO THE HOSPITA
TO THE FUNERA
De filed within 7.
IMPORTANT: I

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

JUNIOU MS

3 0 1993

31. DATE FILED Alberth, Day, Year)



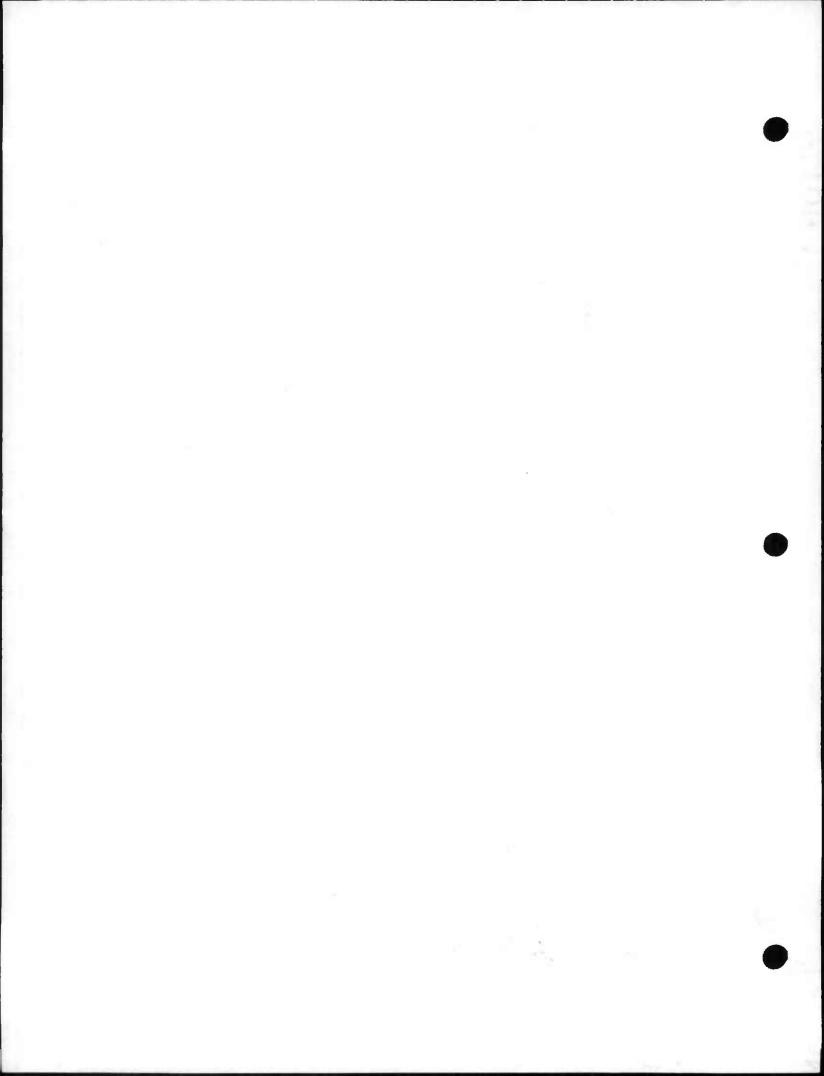
DIVISION OF VITAL RECORDS, P.O. BOX 68760

D)	after
	hours
	24
500	within
100	executed
5	2
5.0	certificate
r L	death
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	that
	requires
5	AM.
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5	PHYSICIAN:
DISION OF ALL AL DECONDS, P.O. BOX 60/00,	PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
5	9
	PITAL

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

	THE STATE OF BEATH HEG. NO.												
	1. DECEDENT'S NAME (First, Middle, Lost) ARRABELLE (AKA) Arbell THORNTON 2. DATE OF DEATH MONTH DAY YEAR MARCH, 26, 1993 9:30 p. M.												
	ARRABELL					MARCH, 26, 1993		93	9:30 p M				
	4. SOCIAL SECURITY NUMBER		5. SEX 1 □ M 2 \ F	5. SEX 6. AGE (In yrs. last		IF UNDER	DAYS			7. DATE OF BIRTH 8. (Month, Day, Year)		8. BIRTH Count	IPLACE (State or Foreign
. 1	219-76-21	77	YRS.	WONTHS	DAYS	HOURS	MIN.	. 06-06	-191		s.c.		
	9a. FACILITY NAME (If not in	stitution, give s	street and number)			9b. CITY	, TOWN	OR LOCAT	ON OF DE	ATH	9c. CO	UNTY OF D	EATH
5	MARYLAND	GENER	AT. HOSPT	TAT.		RAT	BALTIMORE CITY BALTIMORE					DE CTTV	
ह	RESIDENCE OF DEC	CEDENT				Dill	DALITHORE CITY DALITHORE					RE CLII	
DIRECTOR	10a. STATE	10b. COUNT	Υ		10c. CF	TY, TOWN	OR LOCAT	ION					10d. INSIDE CITY LIMITS?
	MD.					Ва	lti	more	e Ci	ty			1 PTES 2 NO
4	10e. STREET AND NUMBER					10f. ZIP CODE				10g. CITIZEN OF WHAT COUNT			
FUNERAL	2271 Re	ister	stown R	≀d.		21215					US	A	
3	11. MARITAL STATUS		12. WAS DECEDEN						IIC ORIGIN? (Specify	les or No-	14. RACI	E — American Indian, k, Whits, etc.	
	1 Never Married 2		FORCES? 1			0 If yes, specify Cuban, Mexican, Puerto (1 □ YES 2 🔀 NO Specify:						k, Whits, etc.	
ВУ	3√ Widowed 4 □ Divo	rced	· ·					-42	ороску			Space	"BIK.
COMPLETED	15. DEC	EDENT'S EDU y highest grade	CATION	16a	DECEDENT'S	USUAL O	CCUPATIO	ON		16b. KIND OF I	USINESS/IN	DUSTRY	
ш	Elementary/Secondary (0		College (1-4 or 5	+)	(Give kind of life. Do NOT u				ng				
P P					1	Iome	maĸ	er		1			
ō	17. FATHER'S NAME (First, M	liddie, Last)						18. MOT	HER'S NA	ME (First, Middle, Meid	n Sumama)		
ш П	Richard	Dunb	ar]	i11	ie Dunb	ar		
m	19a. INFORMANT'S NAME (1	ypa/Print)			196. MAILING	ADDRES	S (Street s			Route Number, City or 1		(in Code)	
임	George	Dunba	r							. Ave.			21215
	20g. METHOD OF DISPOSIT	ION		20b. PLA	CE AND DATE				19 00		OCATION -		
	1 Burial 2 Crematic		oval from State	cemeten	ng Me	ther place)	Pk.					,	, Md.
	21. SIGHATURE OF FUNERA		CENSEE		119 110			ID ADDRE	SS OF FA		11 00	,	, rice.
	- 4-	1	10	4 /						Russ Fu	nera.	l Ho	mo I
	ruser	0	J. Key				222	2 W.	. No	rth Ave	BA	lto.	MD. 21216
23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or real shock, or heert failure. List only one cause on each line.					piratory a	rrest,	Approximate						
	interval Between IMMEDIATE CAUSE (Final Onset and Death												
1	disease or condition SEPTIC SHOCK									i I			
	DUE TO (OR AS A CONSEQUENCE OF):												
z	PNEUMONIA												
CERTIFICATION	Sequentielly list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
8	cause, Enter UNDERLY CAUSE (Disease or inju	ING	urinar	Y TRAC	K INFE	CTIO	N						_
드	that initiated events		DUE TO	(OR AS A CO	NSEQUENCE O	F):							
ᇤ	resulting in death) LAS	T	d										
EDICAL	PARI II. Other significa	nt condition	is contributing to	death but n	ot resulting	in the ur	nderlying	g cause	given in	Part I. 24a. WAS . PERF	IN AUTOPSY ORMED?	24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
음										1 YES	2 NO		COMPLETION OF CAUSE OF DEATH?
ME													1 YES 2 NO
										_			
Ĭ.	25. WAS CASE REFERRED TO	O MEDICAL					26. PL	ACE OF D	EATH (Che	ock only one)	_		
S	EXAMINER? 1 YES 2 NO		HOSPITAL:	ER/Outpatien	nt 3 🗆 DOA	OTHEI		e 5 □ B	asidence	6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF	INJURY	28b. TIR	E OF	28c. INJ	URY AT	T T	28d. DESCRIBE HON	/ INJURY O	CCURED	
		Pending	(Month, D	ay, Year)	IN.	JURY M		RK? /ES 2	NO NO				
ВУ	2 Cutates —	Investigation	28e. PLACE O	F INJURY - A	it home, ferm,	street, fac				261. LOCATION (Street	t and Numb	er or Burel I	Poute Number
COMPLETED		Could not be determined	building,	atc. (Specify)	, , , , , , ,		. , ,	-		City or Town, Sta	le)	or or riorarr	todie Hamber,
9	29a. CERTIFIER			Commence of the second									
P P	(Check only									to the cause(s) and n			
ō.	2 MEDI	CAL EXAMINE	ER: On the basis of e	xamination end	1/or Investigation	on, in my o	pinion, d	eath occu	red at the	time, date and place,	and due to	the csuse(s	s) and manner es stated.
w	296. SIGNATURE AND TITLE	OF CERTIFIE	R A					29c. LIC	ENSE NUN	IBER			(Month, Day, Year)
0	J. Kl	vine	2, 11	7.40							10	3-2	6-1995
٤	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAU	SE OF DEATH	(ITEM 27) (Type	, Print)					1		
	T. PEVZN	ER, M.	D. c/c	o MARY	LAND G	ENER	AL H	OSPT	TAT.				
	31. DATE FILED (Month, Day,	Year)		R'S SIGNATUR									
1	MAR 3 0 1993 Filia Davidson Bondo to												
1													

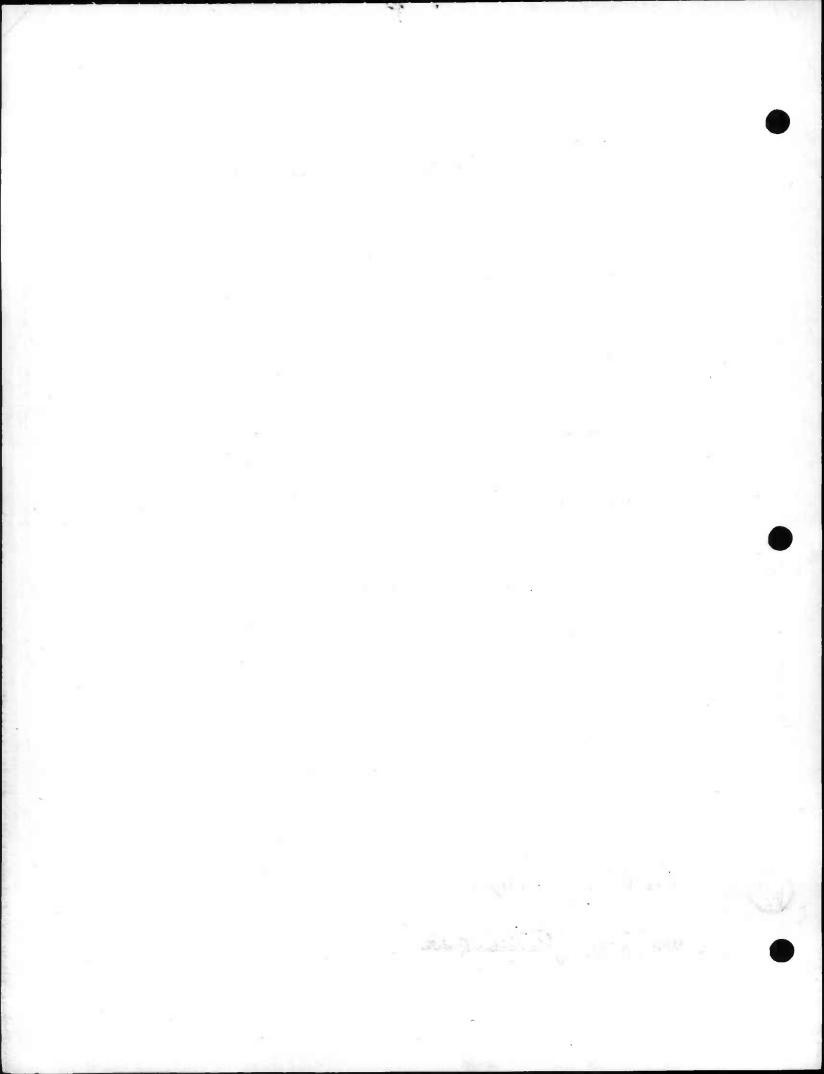


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OF VI	HYSICIAN.
DIVISION OF VITAL RECORDS, P.O. BOX 6876	DSPITAL OR ATTENDING PHYSICIAN: The law remites that the death certificate he executed as
5	OB
	DSPITAL

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN 1993 MILBURN TAYLOR 19 March 2:00 P M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTN IF UNDER 24 HRS. 6. BIRTNPLACE (State or Foreign (Month, Day, Year) 7 - 3 - 20 1 M 2 | F 52 VA 216-14-7626 use as the burlal-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR PERRY POINT VA MEDICAL CENTER ABERDEEN RESIDENCE OF DECEDENT 10a STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD Baltimore 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 924 N. Luzerne Ave. 21205 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY 1 YES 2 NO Specify 3 Widowed 4 Divorced Black COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 12th GSA 17. FATNER'S NAME (First, Middle, Lest) 18. MOTNER'S NAME (First, Middle, Malden Surname) Thomas Taylor notified at Sibbie Tate 띪 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Sibbie T. Moore 924 N. Luzerne Ave./Baltimore, MD 21205 pe 20a METNOD OF DISPOSITION
1 W Burlal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata OATE must TUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. cogarrison forest Va Cem. Owings Mills, examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY MARCH F.H./1101 E. NORTH AVE. the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, ahock, or heert failure. Liet only one ceuse on eech line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Urosepsis event, reculting in death) OUE TO (OR AS A CONSEQUENCE OF) other traumatic LUTINARY Tract Infection
DUE TO (OR AS A CONSEQUENCE OF): PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initieted events OUE TO (OR AS A CONSEQUENCE OF) reculting in deeth) LAST 6 injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS shows any Left Hemiplegia AVAILABLE PRIOR COMPLETION OF CAUSE OF DEATH? t TYES 2 NO 1 YES 2 NO 23 25. WAS CASE REFERRED TO MEDICAL Item 26. PLACE OF OEATN (Check only one) HOSPITAL:
1 N inpetient 2 ER/Outpetient 3 DOA OTHER: t YES 2 XNO 4 Nursing Name 5 Realdence 6 Other (Specify) marked, or 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED 1 ANatural 5 Pending Investiga М BY t YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, term, etreet, factory, office building, atc. (Specify) 28 is 3 Suicida 281. LOCATION (Street and Number or Rural Route Number, City or Town. State) COMPLETED 8 Could not be 4 Nomicide 1X CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as atteted. IMPORTANT: IL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Malle D25622 3-19-93 2 WNO COMPLETED CAUSE OF OEATN (ITEM 27) (Type, Print) STANLEY PHILLIPS, M.D., VA Medical Center, Perry Point, MD MAR 3 0 1993

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

OHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

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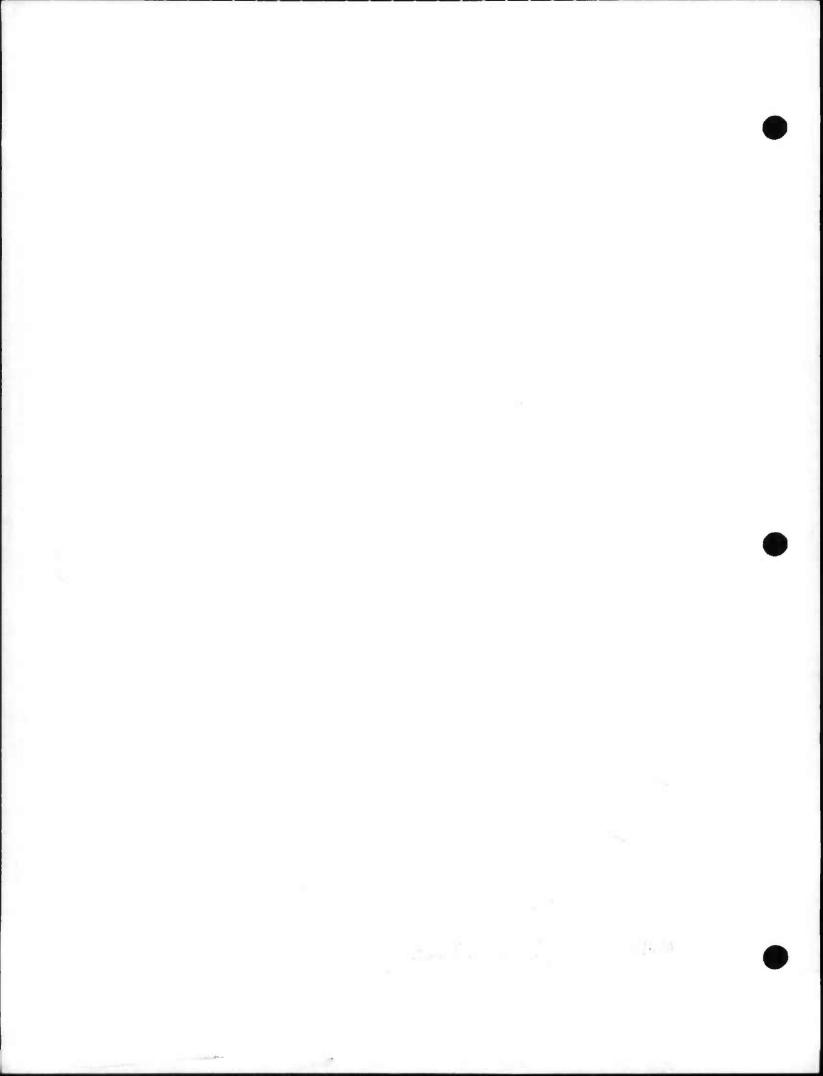
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the houng for the physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be determed to the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netitied at once.

STATE	OF	MARYLAND /	DEPARTMENT	DF	HEALTH	AND	MENTAL	HYGIENE
		CE	RTIFICATE	0	F DEAT	TH		BEG NO

	FOR STATE REGISTRAR	STATE OF MARYLA		MENT DF H		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)	Elizabeth	Ann	ia Tho	mas	2. DATE OF DEATH MONTH DAY	1993	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 212-05-8266	5. SEX 6. AGE (III	yrs. lest birthday) YRS.	F UNDER 1 YEAR WONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) 12/25/19	8. BI	RTHPLACE (State or Foreign country)
œ	Sa. FACILITY NAME (If not institution, give	street end number)			OR LOCATION OF D	EATH	9c. COUNTY O	
5	Mercy Hospita			Balto	.City,	Md.		
DIRECTOR	Maryland –	Y 		to.Cit				10d. INSIDE CITY LIMITS? XX YES 2 NO
3AL	10e. STREET AND NUMBER				ZIP CODE		10g. CITIZEN (OF WHAT COUNTRY?
FUNERAL	9 W.We	St St.	110 401150	1 10 11110 000	21230			SA
BY	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes, sp		NIC ORIGIN? (Specify Yes an, Puerto Rican, etc.) y:	8	ACE — American Indian, Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S EDL (Specify only highest grade Elementary/Secondary (0-12)	JCATION is completed) College (1-4 or 5+)	16a. DECEDENT'S U (Give kind of wo life. Do NOT use	ork done durina ma	ON st of working	16b. KIND OF BUS	BINESS/INDUSTR	γ
MP	6th.Grade		Assem	bly_			dles	
	17. FATHER'S NAME (First, Middle, Last)	homas	Schmi	nako	18. MOTHER'S NA	ME (First, Middle, Maiden	,	Frank
BE	19a. INFORMANT'S NAME (Type/Print)	IIOIII a B				Route Number, City or Town		
٩	Audrey L.Uppe	rman	9 W	.West	St.Balt	to.Md. 21	230	
	20s. METHOD OF DISPOSITION XXBurial 2 Cremation 3 Ren 4 Donation 5 0 Other (Specify)	noval from State come	PLACE AND DATE QU tery, crematory or oth	or niscol			CATION — City o	
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	en Have		Paik, 3/	/27/93 G1		
	- Stoney	1 (1-76	ylo7	McCu	.11y Fur	Balto.Md neral Hom	e.130	30 E.Fort Ave.
		complications that caused List only one cause on ea	the death. Do no ch line.	t enter the mo	de of dying, suc	h as cardiac or respi	ratory arrest,	Approximate interval Between
	iMMEDIATE CAUSE (Fine) disease or condition resulting in death)	a. ARRY	1/14/11	A				Onset and Death
_		MYO	CARA!	16	1NF	ARCTION	V	11
OT I	Sequentially list conditions, if any, leading to immediate	-	CONSEQUENCE OF)					
FIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	C DUE TO (QR AS A	CONSEQUENCE OF)				-	
CERTIFICATION	resulting in death) LAST	d						
AL	PART II. Other significant condition	ns contributing to death bu	rt not resulting in	the underlyin	g cause given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
BY PHYSICIAN: MEDIC						1 YES 2	□ NO	OF DEATH? 1 YES 2 NO
N.								
ICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	ACE OF DEATH (Ch			
HYS	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outpar 28a. DATE OF INJURY	28b. TIME	OF 28c. INJ	URY AT	6 Other (Specify) 28d. DE\$CRIBE HOW II	NJURY OCCURED	
3Y P	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU		RK? /ES 2 NQ	The state of the s		
	3 Suicide 8 Could not be datermined	28e. PLACE OF INJURY - building, etc. (Specif	— At home, farm, st	reet, factory, offic		281. LOCATION (Street a City or Town, State)	and Number or Ru	rei Route Number,
COMPLETED	0001	HCIAN: To the bast of my knowle ER: On the basis of examination						se(s) end manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE NUI			NED (Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WE	1Q COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, I	Print)	~ / 1 /		-10	- / 1 3
	24 DATE BUILD MANAGE DOWN	al passes	THOS					
	MAR 3 0 1993	File Devices A	mplette.					



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR	CERTIF	ICATE O	F DEATH	REG	a. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEA			3. TIME OF DEATH
. 1	Peter J. Vukovan				MONTH 3	19	YEAR 95	627 PMM
	4. SOCIAL SECURITY NUMBER 5. SEX 6. /	AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRD	TH		HPLACE (State or Foreign
	214-30-6743 1X m 2 🗆 F	58 YRS.	MONTHS DAYS		(Month, Day, Y	bar)	Counti	(ער
	9e. FACILITY NAME (If not institution, give street and number)		AL OUTY TOMM	OR LOCATION OF DE	10/23/			aryland
œ 1					АТН	9c. COL	INTY OF D	DEATH
DIRECTOR	University Hospital		Balti	more				
입	10e. STATE 10b. COUNTY	10c CIT	r, TOWN OR LOC	ATION				
£	Md.		timore	ATTON			Į.	10d. INSIDE CITY LIMITS? YES 2 NO
	10e. STREET AND NUMBER	Desi						
₹				IOF. ZIP CODE		10g. Cl7	IZEN OF V	WHAT COUNTRY?
FUNERAL	422 S. Stricker St.			21223			US.	A
ا جَ	11. MARITAL STATUS 12. WAS DECEDENT EV FORCES? 1	ER IN U.S. ARMED	13. WAS D	ECENDENT OF HISPAN	IC ORIGIN? (Spec	offy Yes or No-	14. RACI	E — American Indian,
	IF YES GIVE WAR	OR DATES		specify Cuben, Maxican ES 2 X NO Specify.		tc.)	Speci	k, White, etc.
BY	3 Widowed 4 Divorced			96			Opac	white
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18a. DECEDENT'S	USUAL OCCUPA	TION	16b. KIND C	OF BUSINESS/IN	DUSTRY	
ᄪ	Elementary/Secondary (0-12) College (1-4 or 5 +)	Iffe. Do NOT us	vork done during i e retired.)	nost of working				
릴	10	Insp. (ord.		West	tinghou	se	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			16. MOTHER'S NAM				
	James S. Vukovan				Kur jack			
H	19a. INFORMANT'S NAME (Type/Print)	405 4444 1940						
임	Joan D. Vukovan			t end Number or Rural R				4002
				cker St.,	Partimo	ore, Ma	. 2	1223
	20s METHOD OF DISPOSITION LA Burlal 2 Cremation 3 Removal from State	20b. PLACE AND OATE Of cemetery, cremetery or other		Name of		Oc. LOCATION —		
	4 Donation 5 Cother (Specify)	Loudon Pa			7/23]	Baltimo	re,	Maryland
1	21. SIGNATURE OF PUNERAL SERVICE LICENSEE	Λ	22. NAME	L. Kaufma	HLITY			
	> Lary d. Nou	foreing						1007
	23. PART I. Enter the diseases or complications that can	used the death. Do n	1 2072	Main St.	BIRTIC	rge, Mo	. 4	
	shock, or heart fallure. List only one cause o	on each lina.	ot anter tha h	loue or dying, such	aa cardiec or	reepiratory ar	reat,	Approximate interval Between
1	IMMEDIATE CAUSE (Finel disease or condition	_			60 EW			Onset and Death
J.	resulting in death)	FNOXIC =	ENCE	442084	My			2 WKC
	disease or condition resulting in death) a. Post A OUE TO (OR.) Sequentially list conditions, if any, leading to immediate	AS A CONSEQUENCE OF):	12	/			
z	CARDIO	PULMON	VARY	ARRS	50			2 wks
띭	Sequentially list conditions, If any, leading to immediate	AS A CONSEQUENCE OF):					
5	CAUSE (Disease or Injury		/					
<u> </u>	that initiated events DUE TO (OR .	AS A CONSEQUENCE OF):					
CERTIFICATION	resulting in death) LAST							
- 11	DADT II Other significent conditions contribution to dis-							
℥∥	PART II. Other algorificant conditions contributing to dear					AS AN AUTOPSY ERFORMEO?	24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
ĕ∥	CARDIDYULMONANY AR	11351 6	CLUN	reso in	10 10 Y	ES 2 W NO		COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL	CARDIOPULMONARY AX NEEKS AFTER MANDI	BULAR	RECO	NS TRUC	TUS			1 TYES 2 THO
انِ	SURLERY.						1	
ਤੂ ∥	25. WAS CASE REFERRED TO MEDICAL		26.	PLACE OF DEATH (Che	ck only one)			
ဗ္ဗ	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Vinpatient 2 ER/	Outpatient 3 DOA	OTHER:	ma & C Bankinson is				
<u> </u>	27. MANNER OF DEATH 26s. DATE OF JULIU			me 5 Residence 8	28d. DESCRIBE		O IDED	
	1 Netural 5 Pending	29b. TIME		ORK?	200. DESCRIBE	A INJUNY OC	COHED	1
⋒∥	2 Accident Investigation	NIT	/	YES 2 NO	N/T	/		
		URY — At home, term, st opecify)	treet, factory, off	Ice	28f. LOCATION (S City or Town,	Street and Number Spare)	or Rural R	Route Number,
	W/	H			N	A		
٦	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my k	nowledge, death occurre	d at the time, da	te and pleca, and dua t	o the cause(a) an	nd menner as ste	ted.	
COMPLETED	one) 2 MEDICAL EXAMINER: On the bests of examin) and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIED							
#	15/11	441)		29c. LICENSE NUMI	er c	29d. DAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	PUI '	District	1 237	707		3/1	19/93
	Book 15 11 1 15	OCAIR (ITEM 27) (Type,	1/		M	, ,	1,	2 6
	UKHOLEY C. KUBENISOI	V MU	NIVE	RSITY OF	MARY	2911 fo	105 P.	bow. Ms
	31. DATE FILEO (Month, Day Year) 32. REGISTRAR'S S	GIGNATURE			7	- 774		
	MAR 30 1993 gulie bevide	n-Adaptell						



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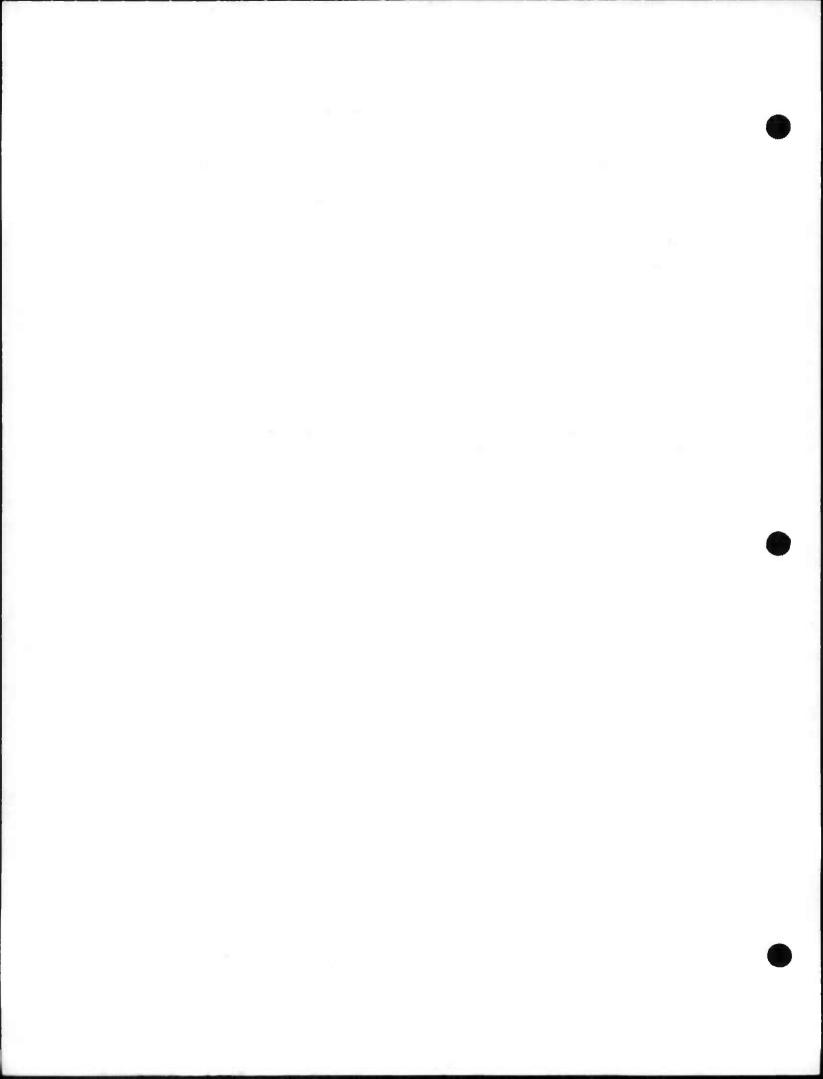
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020	after death. Page 6 may be retained by the page of attending physician.	arthis certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacted for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the uput or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First	, Middle, Last)									2. DATE C	-			3. TIME OF DEATH
Katherine		oit		•	4					MONTH	29	3 :	1953	5:15 Am
4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In	n yrs. lest	birthday)	IF UNDE	DER 1 YEAR			7. DATE O	F BIRTH Day, Year)		8. BIRTH	HPLACE (State or Foreign
120-32-6909		1 ☐ M 2 🂢 F	99		YRS.	MONTHS	DATE	HOURS	MIN.	01-2	1-189	4		stria
9a. FACILITY NAME (If not in						9b. CIT	TY, TOWN	OR LOCATI	ON OF DE	ATH		9c. COL	INTY OF D	
Franklin Sq		lospital			Ψ'	Ba.	ltim	ore				BAL	TIMO	RE COUNTY
RESIDENCE OF DEC	10b. COUNTY	Y			inc. CIT	v TOWN	OR LOCA	ATION						TO A MIGHOR OFFI
Maryland	1-11	imore Cou	int-17				timo							10d. INSIOE CITY LIMITS?
10e. STREET AND NUMBER		TIDIC COL	птсу		<u> </u>	рат		OTE				1 402 017		1 ☐ YES 2 🔯 NO WHAT COUNTRY?
5904 Shady		τ Διπουμο						2123						
11. MARITAL STATUS	<u> </u>	12. WAS DECEDEN	T EVER IN	U.S. ARI	MED	13	2 WAS DE	ZIZS		uc opigin?	Pananthy Van		J.S.A	E — American Indian,
1 Never Married 2		FORCES? 1	1 YES	2 X NO	0		If yes, s	specify Cube	n, Maxica	n, Puarto Ri	can, etc.)	Or HO	Black	k, White, atc.
3 Widowed 4 Divo	rced			-		1		13 2 KM 110	Specing	/ :			Whi	te
15. DEC (Specify only	EDENT'S EDUC y highest grade	CATION completed)			CEDENT'S			TION nost of working	-	16b.	(IND OF BUS	BINESS/IN	·	
Elementary/Secondary (0		College (1-4 or 5		Me. I	Do NOT us	se retired.)	(.)	TOSE OF WORKS	ng					
6th Grade				DOM	esti	C								
17. FATHER'S NAME (First, M	Vddle, Last)							18, MOT	HER'S NA	ME (First, Mi	ddle, Maiden	Surname)		
Joseph Hess									eres					
19a. INFORMANT'S NAME (7)				- 1				t and Number						21237
Marie Kathe				59	904	Shac	dy S	pring	Ave	nue,	Balti	more	. Ma	ryland
20a, METHOD OF DISPOSITI 1 ☑ Burlal 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	ON n 3 🗆 Remo (Specify)	oval from State		PLACEAR	nd date of the Redeck	OF DISPO	OSITION /A			4/1	20c. LO	CATION —	City or To	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY					ur jaun									
· Jan	Men	- M.h	Lun	ne	4	64	415 I	C. Mi Belai	r Ro	ad, E	altin	pre,	Mar	vland 21206
23. PART i. Enter the di shock, or he	seesea, or o	complications tha	it ceused	tha dea	Д До п	ot ente	er the m	oda of dy	ing, suci	h aa cardii	c or respi	ratory ar	reat,	Approximata
IMMEDIATE CAUSE (FIR		blot othy other	186 GH 50.	SII III.										intarval Between Onset and Death
disease or condition resulting in death)	→	 Pneu 	monia	a										
			(OR AS A C		UENCE OF	7):								
Sequentielly list conditi	ions.	b												
If any, leading to immer cause. Enter UNDERLYI	diata	DUE 10	(OR AS A C	CONSECU	UENCE OF	ን:								
CAUSE (Disease or Inju		c. DUE TO	(OR AS A C	CONSEC	HENCE OF	E).								
that initiated events reaulting in deeth) LAS	Т		(OII NO N =	JOHOLO	DEMOE OF):								
12.0	-	4												
PART II. Other significa	nt condition	s contributing to	death but	t not re	aulting I	n the u	underiyir	ng ceuse (olven in	Part I.	4a. WAS AN		24b.	WERE AUTOPSY FINDINGS
											PERFOR			AMILABLE PRIOR TO COMPLETION OF CAUSE
														DF DEATH? 1 YES 2 NO
										_				
25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL							PLACE OF O	EATH (Che	ack only one)				
1 YES 2 NO		HOSPITAL:	ER/Outpat	dlant 3	DOA	OTHE		me 5 🗆 Ra	sidence	6 🗆 Other	Specify)			
27. MANNER OF OEATH		28a. DATE OF (Month, Da			26b. TIME		28c. IN	JURY AT			RIBE HOW II	NJURY OC	CUREO	
	Pending Investigation					M		YES 2	NO					
3 Suicide 6 .	Could not be	26a. PLACE Of building,	F INJURY -	— At hor	ne, farm, s	dreet, fac	ctory, offi	ica		261. LOCAT	ION (Street a	ind Numbe	r or Rural F	Route Number,
4 Homloide	determined			<i>"</i>						uny	nown, orono,			
29a. CERTIFIER (Check only 1 CERT	IFYING PHYSIC	CIAN: To the best of	my knowle	idga, dea	th occurre	ed at the	time, dat	te and place	and dua	to the caus	ofa) and man	ner sa sts	ted.	
														a) and manner as stated.
	OF CERTIFIER							-	NSE NUM		17			(Month, Day, Year)
XWE	ONV	21)										-	2/21	G /S .7
30. NAME AND ADDRESS OF	PERSON WHO	O COMPLETED CAUS	SE OF DEAT	TH (ITEM	27) (7)00.	Print)		1					1/2	7/5
South L	1, 18	ween-e	1)	0									/	r
IM A D	Nari /	32. REGISTRA	1					10.	_					
MAK 3	0 1993	Julia L	Tevidsor	n- Par	ndelle									



TO New Mark L. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be well after the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTARE If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

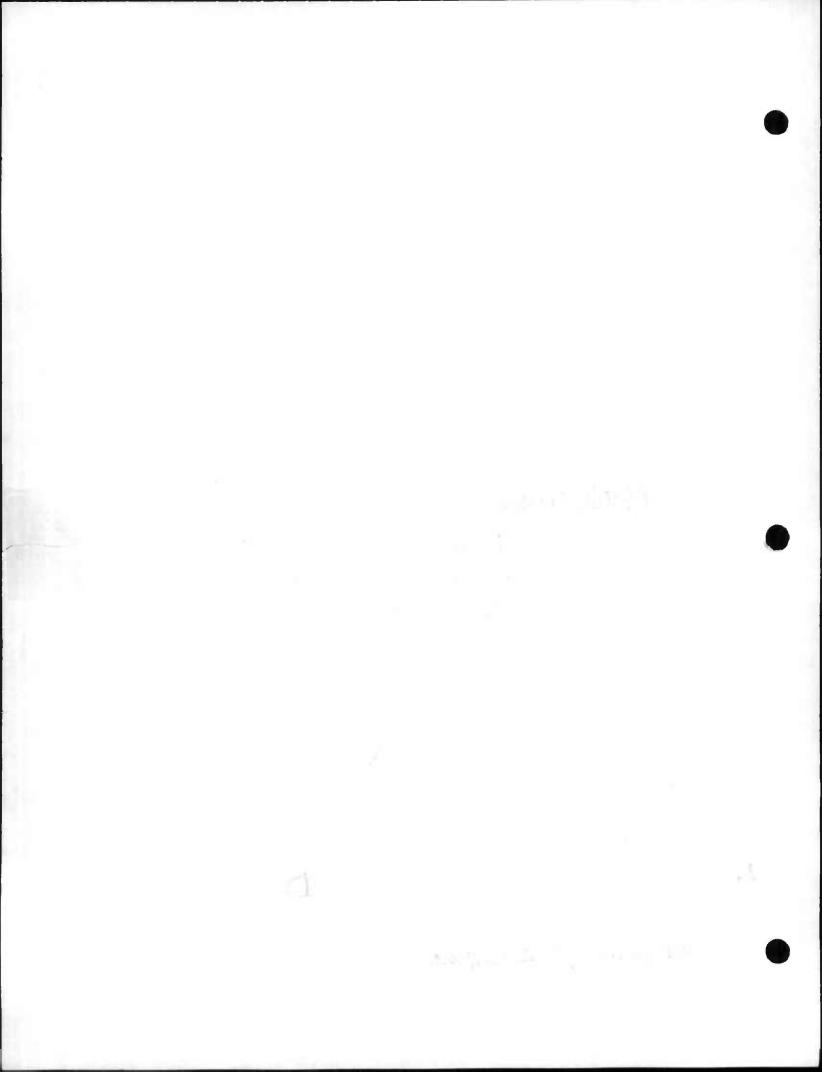
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DIVISION OF VITAL RECORDS,	
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC	MENT OF HEALTH AN	ID MENTAL HYGIEN		3 08582
	1. DECEDENT'S NAME (First, Middle, Last), 1. DECEDENT'S NAME (First, Middle, Last), 4. SOCIAL SECURITY NUMBER	SON 8, AGE			2. DATE OF DEATH MONTH D	6	YEAR 3. TIME OF DEATH
	220-05-4015	1 M 2 DF	22	F UNDER 1 YEAR IF UNDER 24 HE DAYS HOURS MIL	40.0 - at 0	2	B. BIRTHPLACE (State or Foreign Country)
TOR	90. FACILITY NAME (If not institution, give s PKESU PE RESIDENCE OF DECEDENT	Numbers	Home	Pikesuile	F DEATH	9c. COUNT	Y OF DEATH
DIRECTOR	106. STATE 10b. COUNTY		(1)	OUILLE			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER Sud 6	rook La	ne	10f. ZIP CODE 2/726	8	10g. CITIZI	EN OF WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 _ YES IF YES, GIVE WAR OR D	2 NO		SPANIC ORIGIN? (Specify Yearto Rican, atc.)	or No 1	4. RACE — American Indian, Black, White, etc. Specify: Black
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	18e. DECEDENT'S US (Give kind of work life. Do NOT use n	VIAL OCCUPATION k done during most of working elired.)	16b. KIND OF BU	SINESS/INDU	STRY
BE COM	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S	S NAME (First, Middle, Maiden	Sumeme)	
TO B	190. INFORMANT'S NAME (Type/Print) &	tolloman	19b. MAILING AL	Druid Park		n, State, Zip C	Baltund 2121
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Reme 4 Donetion 5 Other (Specify)	oval from State 20b	PLACE AND DATE OF I	place PME terry	DATE 20c. LO	CATION — CI	ty or Town, State
	21. SIGNATURE OF FUNERIAL SERVICE LETC	Pron)	1.10	122, NAME AND ADDRESS OF March F.	F FACILITY 4. West 4.	chas	h Aue
		complications that caused List only one cause on a	the deeth. Do not ech line.	enter the mode of dying,	such as cardiec or respi	iratory arres	st, Approximata interval Between
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	Kesy	pirato	my Clv	18+		Onset end Deat
Z		DUE TO LOH AS V	CONSEQUENCE OF):	ue			
SATIO	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING	DIA TO (OR AS A	CONSEQUENCE OF	á.		-	
CERTIFICATION	CAUSE (Disease or injury thet initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):				
_	PART ii. Other significent conditions	s contributing to deeth b	ut not resulting in t	he underlying ceuse given	in Part i. 24e, WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICA					PERFOR		AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PLACE OF OEATH	(Check only one)		
HYSIC	1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outp 28e. DATE OF INJURY	atlent 3 DOA 4	THED:			
BY PI	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME O		28d. DESCRIBE HOW II	NJURY OCCU	RED
	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	— At homa, ferm, atre	et, factory, office	28f. LOCATION (Street of City or Town, State)	and Number or	Rural Route Number,
COMPLETED				t the time, date end place, end in my opinion, death occured at			
BE C	296. SIGNATURE AND TITLE OF CENTIFIER	. 1/	N	29c. NICENSE			SIGNED (Month, Pay, Year)

E OF DEATH (ITEM 27) WAY

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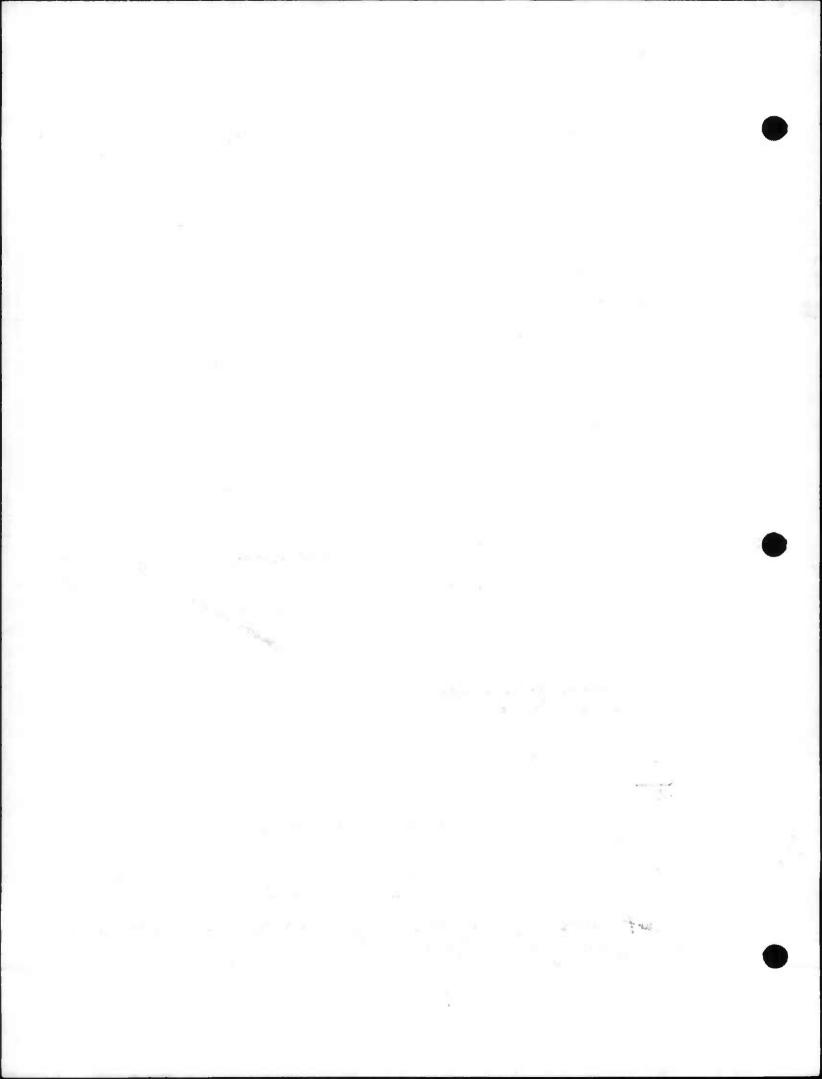
OHMH-16 Rev 1/89



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	REGISTRAR 1. DECFOENT'® NAME (First, Middle, Last)	. 1	CERTI	FICATE OF	DEATH	REG. NO).	3. TIME OF DEATH
	Eft	ie Mo	Water	5		MONTH D	5 93	AR _ US
	4. SOCIAL SECURITY NUMBER 220–18–5828	1 🗆 M 2 💢 F	(In yrs. last birthda	MONTHS DAVE	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 4 - 25 - 19	26	MRTHPLACE (State or Foreign Country)
стов	96. FACILITY NAME (If not institution, give THE JOHNS HOPKIN RESIDENCE OF DECEDENT			100	ORE CITY	EATH	BALT]	
DIRE	10e. STATE 10b. COUNT	TY		timore	TION			10d. INSIDE CITY VIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 3022 Hanlon Av	enue		10	7. ZIP CODE 21210	6	10g. CITIZEN	OF WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2XXX Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2 V NO	If yes, ap	CENDENT OF HISPAR Becity Cuban, Mexica 2 2 NO Specify	NIC ORIGIN? (Specify Yein, Puerto Rican, etc.)		RACE — Americen Indien, Bleck, White, etc. Specify: Black
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)		(Ghm kind)	'S USUAL OCCUPATION of work done during monuse retired.) '1 SOY	ON sst of working	Bureau Enforc	of Sup ement	port
⁵ ևս I	17. FATHER'S NAME (First, Middle, Last) Benjamin Harvey	, Sr			18. MOTHER'S NA	ME (First, Middle, Maiden Parker	Sumame)	
10 B	190. INFORMANT'S NAME (Type/Print) James Waters					Route Number, City or Tow Baltimore,		
100	20e. METHOD OF DISPOSITION 1 A Buriel 2 Cremation 3 Rer 4 Donation 5 Other (Specify)		b. PLACE AND DAT	EOFDISPOSITION (Ne	ame of		OCATION — City	or Town, State
	21. SIGNATURE OF FUNERAL SERVICE L		<u> </u>	22. NAME A	arch F/H			
event, the medical	23. PART I. Entar tha diseasea, or ahock, or heart feilure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that cause List only one cause on Reh	ad the death. Deeth line.	not antar tha mo	eda of dying, auci	h aa cardiac or reap	olratory arreat,	Approximata Interval Between Onset and Death
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated avents resulting in daath) LAST	DUE TO (OR AS	A CONSEQUENCE	353	7	Of the state of the	MOREN EN	4
: MEDICAL CE	PART II. Other significant condition Covonary Cardian	Andrew Jisca		g in the undarlying	g cause given in	Part I. 24a. WAS AN PERFOI	RMEO?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 NO	HOSPITAL:		OTHER:	ACE OF DEATH (Ch			
ВУ РНУ	27. MANNER OF DEATH Active Accident S Pending Investigation	28e. DATE OF INJURY (Month, Pay, Year)	28b. T	ME OF 28c, INJ	URY AT PRES 2 NO	8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCURE	D
TED	3 Suicide 8 Could not be determined	28s. PLACE OF INJUR building, etc. (Spe		HODKINS (ath Lab	281. LOCATION (Street City or Town, State)		iral Route Number,
흴르		ER: On the basis of examination	wledge, death occu	rred at the time, date				se(e) end manner ee stated.
TO BE CON	296. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON W	MD CE	hiof Res	Lf.	29c. LICENSE NUN D 39 /	IBER	29d. DATE \$4G	25/93
	Lampbel	Tolus 37 megistranisasi	Hopkius	Hosp.	600 N. W.	olfe st. Be	1to , MI	21287.

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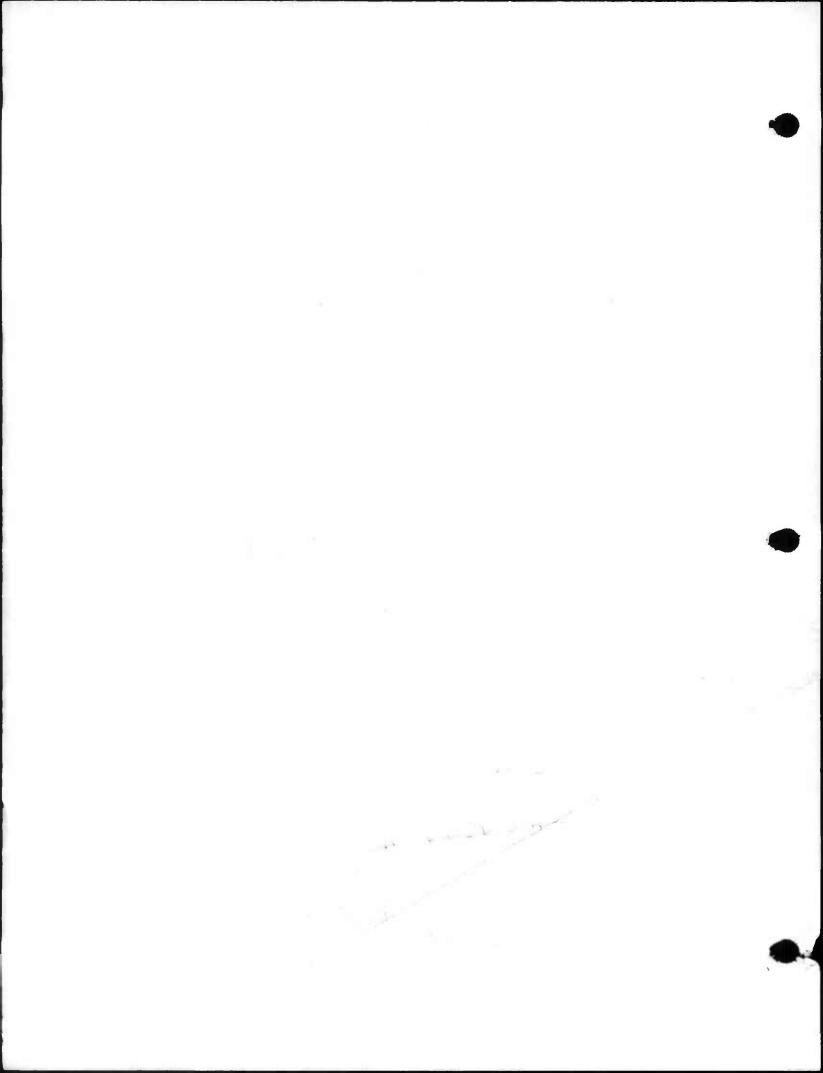


eath. Page 6 may be ratained by the hospital or attending physician. Inversal director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within "amours after death. Page 6 may be retained by the bost TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	DIVISION OF VITAL RECORDS, F.O. BOX 13146,	DALLIMORE, MARTLAND
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-	ours after death. Page 6 may be retained by the hos
MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fille be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation,	d in by the funeral director, page 5 should be detache or removal.
	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the	medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR

	- REGISTRAR CERTIFICATE OF DEATH REG. NO.
	1. DECEDENT'S NAME (First, Middle, Last) JAMES L.B. WAS 20 93 11:30 AM
	4. SOCIAL SECURITY NUMBER 2/8-1/0-2334 1 Mm 2 F 72 YRS. 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) (Month, Day, Year) 9 Country) U.S. 4
DIRECTOR	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMENT RESIDENCE OF DECEDENT 9c. COUNTY OF DEATH C'TY
ᇣ	10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY
	UD: CITY BALTIMERE 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY?
FUNERAL	3219 MASSACHUSETTS AU 21229 USA
BY FU	11. MARITAL STATUS 1 Newer Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECEDENTED TO F. HISPANIC ORIGIN? (Specify Yea or No— lif yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Black, Whita, etc. Specify:
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
우미	City Employee - Retired
	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Lycy Qyich
씲	
욘	Edna D. Ward 3219 Massachuesetts Ave, Balto, md.
	20s. METHOD OF DISPOSITION 1 Purisi 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cometery, crematory or other place) ND. NAT. MC. PK Land, MD.
ļ	1 Pariet 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY W.M. C. Brown Comm. F. H.
	WMC Brow 1206 W. North Auc BAHO, MD 21217
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiec or reepiratory erreet, ahock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Final
	disease or condition resulting in death) a. Heyatic enceptral of the days oue to (or as a consequence of):
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events b. Due to (or as a consequence of): ### Color of the conditions of the consequence of the
ERT	reaulting in death) LAST
DICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO NO NO NO NO NO NO
PHYSICIAN: ME	1 YES 2 NO
5	25. WAS CASE REFERREO TO MEDICAL EXAMINER? HOSPITAL: OTHER:
छ ।	1 YES 2 NO Unimpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)
	27. MANNER OF OEATH 28s. DATE OF INJURY (Morith, Dey, Year) 28s. INTIME OF INJURY AT WORK? 1 Yes 2 NO 28s. INJURY AT WORK? 1 Yes 2 NO
TED BY	2 Accident investigation 3 Suicide S Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)
COMPLETED	29a. CERTIFIER (Check only one) 1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and mennar as stated. 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIED 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) \$\int \frac{1}{2}\frac{1}{2}\frac{1}{2}\frac{1}{2}}\$
-	30. NAME AND ADDRESS PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print). Sevans My 700 Washington Plus, Batto, Md 21230
	MAR 3 0 1993 guild Deutsch Range

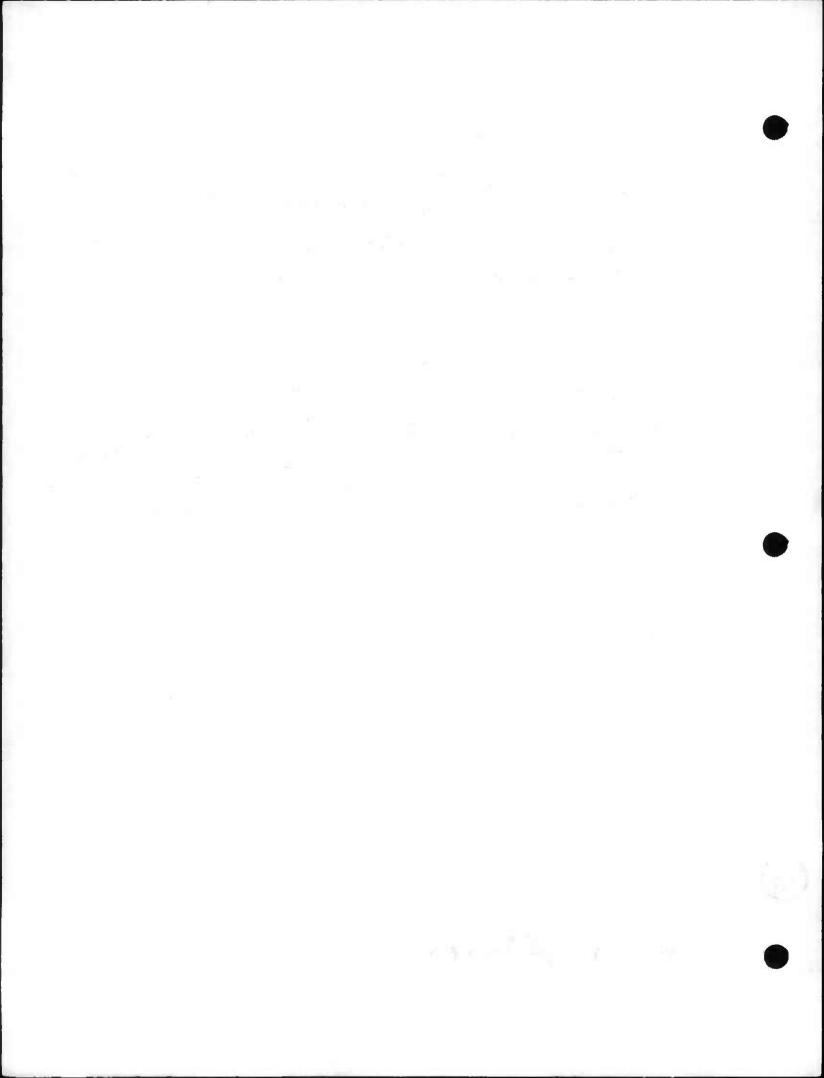


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FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1. DECEDENT'S NAME (First, Middle, Lest) Virginia Washington	2. DATE OF DEATH DAY	year 8:37 P m
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (IN VIS. less birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign
229-28-1971 1 M 2 F 70 YRS. MONTHS DAYS HOURS MIN.	(Month, Day, Year)	2 Virginia
96. FACILITY NAME (If not institution, give street and number) 96. CITY TOWN OR LOCATION OF DE		DC. COUNTY OF DEATH
RESIDENCE OF DECEDENT 100. STATE 100. CITY, TOWN OR LOCATION MAYUMANO DAIL TOWN OR LOCATION DAIL TOWN OR LOCATION	SLOWN	
100. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY
		1 YES 2 NO
100. STREET AND NUMBER	, 1	log. CITIZEN OF WHAT COUNTRY?
The street and number to the street and street		11.5,A,
II . I	n, Puerto Ricen, atc.)	No— 14. RACE — American Indian, Black, White, etc.
3	; *	Stry CK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	16b. KIND OF BUSIN	ESS/INDUSTRY
Elementary/Secondery (0-12) College (1-4 or 5+) life. Do NOT use retired.)		
17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NA		
	ME (First, Middle, Maiden Sui	mame)
19 INFORMANT'S NAME (Trop/Print)	Soute Number, City or Town, 5	State Zin Code)
Mrs. Anna Mason 326 W. Garrison	1.0	
206. METHOD OF DISPOSITION 206, PLACE AND DATE OF DISPOSITION (Name of		TION — City or Town, State
4 Donation 5 Other (Specify) (SREEN Mount Cens	BA	170. mc.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE	SS FUN	leral Hone
Joseph L. Russ 2002 W. Nos	to Ave BA	1x, md. 21216
23. PART i. Enter the diseases, or complicatione that caused the deeth. Do not anter the mode of dying, auc ehock, or heart failura. List only one ceuse on each line.	ee cerdiac or reepirat	
IMMEDIATE CAUSE (Final		Interval Between Onset and Death
disease or condition - Ventrulary fulful ation		
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentielly list conditione, it any, leeding to immediate b. DUETO OR AS A CONSEQUENCE OF S	2	
Cause (Disease or injury	domentia	
that initiated events Due TO JOR AS A CONSEQUENCE OF:	(00)	7
Sequentielly list conditione, it any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		
	Part I. 24e. WAS AN AU	
PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Commany and underlying cause given in	PERFORME 1 YES 2	COMPLETION OF CAUSE
Diabetes mollitus		OF OEATH?
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	ick only one)	
1 VES 2 V NO 1 V Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT		
II I V Metural 5 Pending	28d. OEŞCRIBE HOW INJU	URY OCCUREO
2 Accident Investigation 2 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office	281, LOCATION (Street and	Number or Rural Route Number,
4 Homicide determined	City or Town, State)	The state of the s
11 11	to the cause(e) and manne	r an eleted
29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end piecs, and due one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the		
29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUN	BER 2	9d. OATE SIGNED (Month, Day, Year)
		3/27/93
00 (Parlan) "//(T)		
O SOSION TO 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
Soston MA		

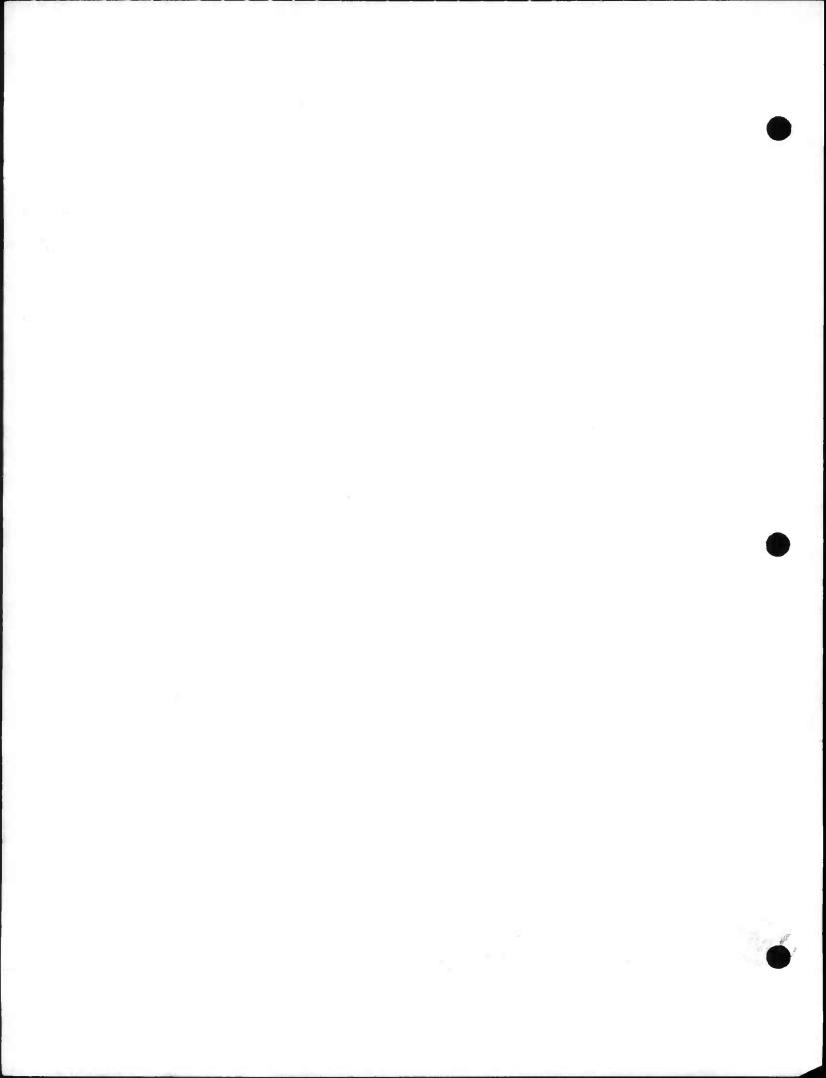


1 - FOR STATE REGISTRAR

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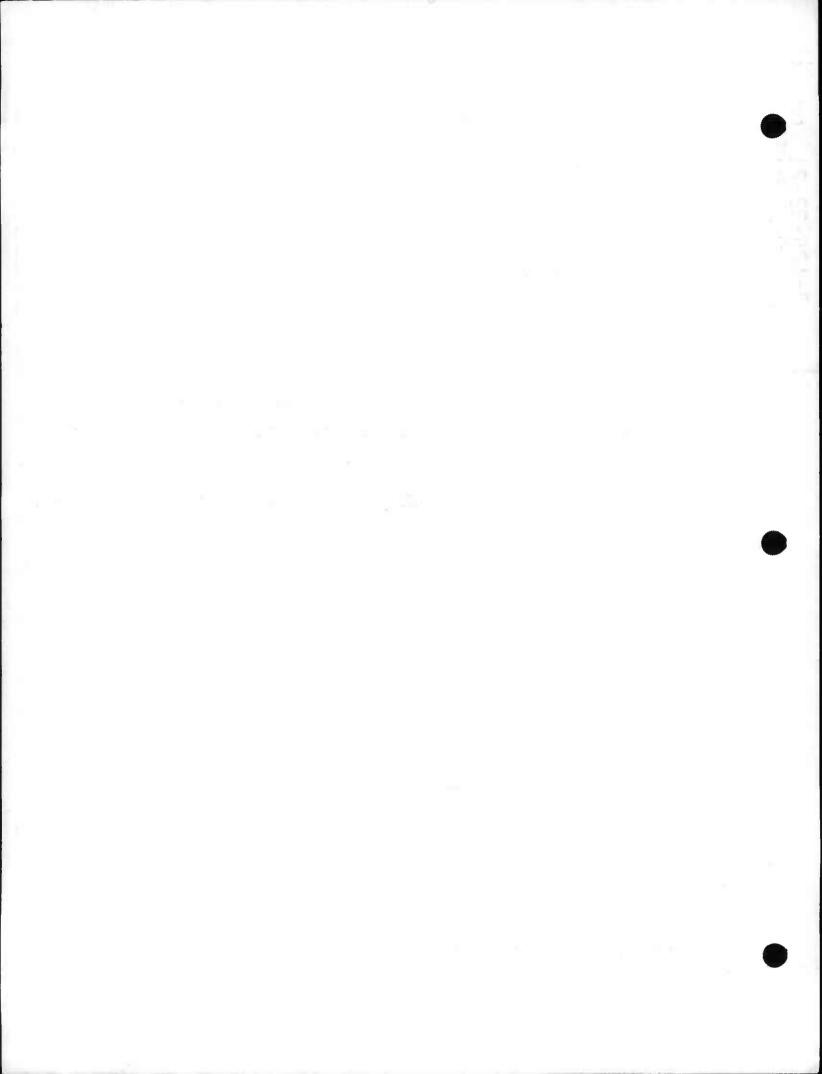
	1. DECEDENT'S NAME (First, Middle, Last)				-				2. DATE OF	DEATH		3. TIME OF DEATH
	ERIC WASHINGTO	N							MARCH	24,	1993	2:00 P
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	lest birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF I			BIRTHPLACE (State or Foreign
1	213-76-7585	XX M 2 - F	32	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, De	8 – 60		Country) M.D.
1	9e. FACILITY NAME (If not institution, give	street and number)	02		9b. CITY,	TOWN O	R LOCATI	ON OF DE		<u>0 - 0 0</u>	9c. COUNT	TY OF DEATH
CTOR	THE JOHNS HOPKIN	S HOSPITA	J		RAI	TIMO)RF	CITY	V	l		TIMORE
5	RESIDENCE OF DECEDENT							CII			DALI	THUKE
DIRE	MD 10a. STATE 10b. COUNT	TY.			Balt							10d. INSIDE CITY LIMITS?
	10e, STREET AND NUMBER				Dail							1)(T)(YES 2 NO
RAL	1654 Kingsway	Count				101.	212				_	S . A .
FUNER	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S.	BMED	12 V	Me nece			IIC ORIGIN? (S	14 14		
	1 💢 Never Married 2 🗌 Merried	FORCES? 1	YES 2 Y	NO	11	yes, spe	city Cube	n, Mexica Specify	n, Puerto Ricar	n, etc.)	OF 140-	4. RACE — American Indian, Black, White, etc.
ā	3 Widowed 4 Divorced				Ι.	_ TES	5XXNO	Specify	<i>r</i> .			specify: Black
	15. DECEDENT'S EDI (Specify only highest grad	JCATION completed)		Give kind of				10	16b. KIN	ID OF BUSI	NESS/INDU	STRY
Ē	Elementary/Secondary (0-12)	College (1-4 or 5	-)	to. Do NOT us	se retired.)			•				
COMPL	O U [] 17. FATHER'S NAME (First, Middle, Last)		U U	nemp	тоуе	u						
- 1	Daniel Washin	aton				- 1			ME (First, Middl rice			on
2	196. INFORMANT'S NAME (Type/Print)	90011	Ι.	ION MAIL INC	. 40000000	(0)			Route Number, (_	
임	Daniel Washin	aton	1	1654	Kin	Q S W	ia vumber I a V	Ct.	/Balt	imor	e. M	D 21218
	204, METHOD OF DISPOSITION		20b. PLAC	EANDDATE					DATE	_		fy or Town, State
	大長Burial 2 Cremation 3 日 Ren 4 Donation ら Other (Specify)	noval from Stata	centerecyb	"U"towos	othe Mee'm	. P	ark		1	Arb	utus	, MD
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	1				D ADDRE					
Î	Main	NIG	100		Wm	. C	. M	arc	h F.H	./11	01 E	. North Ave
┪	23. PART i. Enter the diseases, pr	complications the	t caused the d	leath. Do r	not enter i	the mor	te of du	ing eucl	h as cardino	Dr monin	atoni ama	at L Assessition
	ahock, or heart failure. IMMEDIATE CAUSE (Finel	List only one cau	se on aech ili	10.			ac b. ayı	ing, odd	ii da caidiac	Di reapire	story arres	intervai Batwee
	disease or condition	U.	nardo.	-0								Onset and Deat
ı	resulting in death)	DUE TO	OR AS A CONS	ECUENCE O	IF):							1 1) ay
∠ ∥	200700000000000000000000000000000000000	Liv	er Fo	wilve.	e							1 Month
CALION	Sequentially list conditions, if any, leading to immediate	-	(OR AS A CONS									
5	CAUSE (Disease or Injury		vilodo	_ ci	rrho	Vin 2						5 years
	that initieted events resulting in death) LAST	DUE TO	(OR AS A CONS	EOUENCE D	F):							
CENTILL		d										
- 11	PART ii. Other aignificant condition							iven in	Part i. 24e	. WAS AN A		24b. WERE AUTOPSY FINDINGS
MEDICAL	Adult reini	ratory d	istress	54	ndn	me				PERFORM		AVAILABLE PRIOR TO COMPLETION OF CAUSE
											A	OF DEATH? 1 □ YES 2 NO
PHISICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:					ACE OF D	EATH (Che	ock only one)			
	1 YES 2 KNO	1) Inpatient 2	ER/Outpatient	3 🗆 DOA	OTHER 4 - Nursi		5 🗆 Ra	sidence	6 Other (Sp	ecify)		
	27. MANNER OF DEATH 1 X Natural 5 Pending	28e. DATE OF (Month, D		28b. TIM	JURY	28c. INJU WOR			26d. DESCRIE	BE HOW IN.	JURY OCCU	RED
ř	2 Accident Investigation				М		ES 2	NO				
	3 Suicide 6 Could not be 4 Homicide determined	building,	F INJURY — At t etc. (Specify)	iome, ferm, s	street, facto	ry, office			261. LOCATIO City or To		d Number or	Rural Route Number,
	29a, CERTIFIER											
	(Check only											
È		ER: On the basis of a	camination and/o	r investigatio	on, In my op	inion, de	eth occur	ed at the	time, deta and	place, end	due to the	ceuse(e) end menner ee stated.
S .							00- 1400		IBER		204 DATE S	NONE AL
3	29b. SIGNATURE AND TITLE OF CONTIFIE	R () /1						NSE NUM			-20. DATE:	SIGNED (Month, Day, Year)
22	29b. SIGNATURE AND TITLE OF CERTIFIE	6 Wil	MD	F11 0			L 14	_			▶ 3	124/93
20 10		O COMPLETED CAUS					L14	18	Tal		> 3/	124/93 Ninor, MD
TO BE COMPLETE	29b. SIGNATURE AND TITLE OF CERTIFIE	HO COMPLETED CAUSE	10 7.				L14	18	, Tour		> 3/	124/93
20 10	296. SIGNATURE AND TITLE OF CENTIFIE 30. NAME AND ADDRESS OF PERSON WE STEEL PRO A V 5	HO COMPLETED CAUSE					L14	18	, Tour		> 3/	124/93 Ninor, MD

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



NJ

2		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND /	DEPART ERTIFI	MENT OF CATE O	HEALTH AN	ND MEI	NTAL HYGIEN		08587
		1. DECEDENT'S NAME (First, Middle, Last)	(JESSIE)					2.	DATE OF DEATH		3. TIME OF DEATH
6		JESSE WILLIAMS							IARCH 24.	1993	
40		4. SOCIAL SECURITY NUMBER		'In yrs. lest 79		IF UNDER 1 YEAR	1	IRS. 7. 1	DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)
모		238-28-7164	V-V-V	13	YRS.	IONI III	HOURS	IN.	12-17-	13	NC
2, 3 should	DIRECTOR	98. FACILITY NAME (If not institution, give str THE JOHNS HOPKINS RESIDENCE OF DECEMENT					MORE CI				TY OF DEATH IMORE
Pages 1.	EC.	10a. STATE 10b. COUNTY			10c. CITY,	TOWN OR LOC	ATION				10d, INSIDE CITY
mit. Pag		MD				timore	е				1 N YES 2 NO
physician. burial-transit permit.	FUNERAL	2638 E. Oliver	St.				212 3 3			USA	EN OF WHAT COUNTRY?
24 hours after death, Page 6 may be retained by the hospital or attending physician, filled in by the funeral director, page 5 should be detached for use as the burial-train fon, or removal. The medical examiner must be notified at once.	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2X XN	MED IO	If yes,	ECENDENT OF H specify Cuban, M ES 2 NO S	lexican, Pu	ORIGIN? (Specify Yes werto Rican, etc.)		14. RACE — Americen Indien, Black, White, etc. Specify: Black
il or attending for use as the	ETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)		(Gh	CEDENT'S U ive kind of wo Do NOT use	ISUAL OCCUPA ork done during i retired.)	TION most of working		16b. KIND OF BUS	SINESS/INDU	JSTRY
the hospital or detached for once.	COMPL			Car	reta	ker					
e detach	00	17. FATHER'S NAME (First, Middle, Last)							First, Middle, Maiden	Sumame)	
ed by t	BE	Dee Williams 190. INFORMANT'S NAME (Type/Print)			- F - LYROY -				Powel1		
5 should to	유								Number, City or Town		
ay be		Emma Johnson 200. METHOD OF DISPOSITION	20b.			E. UI					MD 21213
e 6 ma ector, p must		1 Donetion 5 Other (Specify)			metory of othe		<i>Мат</i> те от	i			County, N.C.
leath. Page 6 m funeral director, xaminer must		21. SIGNATURE OF FUNERAL SERVICE LICE			,		AND ADDRESS O	OF FACILIT			0041103, 1110
death, Pag tuneral di i. examiner		1	V4 =	-	_	WM	C. MAR	CH E	F H/110	1 F	NORTH AVE.
rs after or by the removal.		23. PART I. Enter the diseasee, or co	omplications that caused	the der	ath. Do no						
24 hours after filled in by the on, or remove the medical		shock, or heart fellure. L	ist only one couse on ea	ach line.			1000 v,		beines of took.	10tory orto	Interval Between Onset and Death
ely fills nation, the		disease or condition resulting in death)	Pheun	2DK							
completely iaf, cremat event, 1		resulting in death)	OUE TO (OR AS A	CONSEQ	UENCE OF)	:					3 da.
be executed within cian and completely for to burial, cremat raumatic event, it	N	Sequentially list conditions,	aspir	-at	ron						17da.
be ex cian a for to	CATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEC	UENCE OF):	1.60	Line	F		11	Cancer (unknow
physi propried	FIC	CAUSE (Disease or Injury that initiated events	DUE TO OR AS A	CONSEO	LUENCE OF):	SOSTVU	Clion	71	omco	1104	Cancer money
attending attending intal Hygier	ERTIFI	resulting in death) LAST									
the death the atter Mental	CE	DART II Other clanificant conditions									
~ ~ ~	CAL	PART II. Other significant conditions	contributing to death bu	ut not re	sulting in	the underlyl	ng cause give	n in Part	1. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO
ENDING PHYSICIAN: The law requires that the R. After this certificate has been signed by the death with the State Dept. of Health and Its marked, or Item 23 shows any Ir.	EDICA	710							1 YES 2	P NO	COMPLETION OF CAUSE DF DEATH?
requires been sign of Heal	Σ									*	1 TES 2 NO
SICIAN: The law requestrificate has been the State Dept. of the State Dept. of them 23 sho	SICIAN:	25. WAS CASE REFERRED TO MEDICAL				26	DI ACS OF OFATI	· Chaok a	*****		
IN: The ficate h State i	SICI	EXAMINER?	HOSPITAL:	atlant 3		OTHER:	PLACE OF OEATH				
SICIAL certiff th the d, or	PHYS	27. MANNER OF OEATH	28e. OATE OF INJURY	Miera 3	26b. TIME	OF 28c. II	ome 5 - Reside		Other (Specify) 1. DESCRIBE HOW IN	NJURY OCCI	URED
DING PHYS After this death with	ВУ Р	1 Natural 5 Pending	(Mgnth, Day, Mg)	- 1	INJUI	RY W	VORK? YES 2 NO				71165
NDING R: After ar death		3 Suicide 8 Could not be	28e. PLACE OF INJURY - building, etc. (Specia	- At hon	ne, farm, atr	eet, factory, off	lice	281.		and Number o	or Rural Route Number,
ECHAR:	ETED	4 Homicide determined	Outside the later	197					City or Town, State)		
色觀釋	PLE	29e. CERTIFIER (Check only	CIAN: To the best of my knowle	edge, dea	ath occurred	at the time, da	its and plecs, end	due to th	ne ceuse(s) end men	mer as states	d.
1	COMPL										ceuse(s) and menner es stated.
E FUI	ш	29b. SIGNATURE AND TITLE OF CERTIFIER	223				29c. LICENSE	NUMBER		29d. OATE	SIGNED,(Month, Day, Year)
TO THE TO THE Be filed V	10 B	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	T' ATEM						▶ 3/	24/93
		Kelly 0 Don	nell MI).	Joh		oplan	1 4056	o. ta	l -600.	N.WO	R & 21287
		31MAR 23-0 1993 &	A STATE OF S	Her.							



TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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uncate	physic	ene pric	ther tr
am cer	ttending	tal Hygi	or item 23 shows any injury, or other traumatic of
the de	y the a	nd Men	Injur
res thai	igned t	ealth a	vs any
w requi	been s	pt. of H	3 shov
The la	ate has	tate De	tem 2
SICIAN	certific	h the S	d. or 1
ING PH	THE FUNERAL DIRECTOR: After this cert	eath wit	marke
TEND	TOR: A	after d	28 8
L OR A	L DIREC	? hours	item.
OSPITA	UNERAL	rithin 72	ANT: II
JE P	THE F	w pally is	APORT.
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	FOR 1 - STATE REGISTRAR	STATE OF MAR			MENT OF H		MENTAL HYGII			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH			IME OF DEATH
	Lillian Wentwo	rth					03	23 9°	YEAR	м
			NGE (In yrs. les		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		B. BIRTHPLAC	CE (State or Foreign
	213 74 8264	1 M 2 F	86	YRS.	DAYS	HOURS MIN.	(Month, Day, Year, 10/5/19	06	Country) Mary 1 TY OF DEATH	
TOR	706 Holy Cross R	oad			Balti				e Arur	
EC	10a. STATE 10b. COUNTY			10c. CITY, 1	OWN OR LOCAT	ION			10d	INSIDE CITY
DIR	Maryland Anne	e Arundel		Ba1	timore				1 🗆	LIMITS? YES 2 W NO
AL	10e. STREET AND NUMBER				10:	. ZIP CODE		10g. CITIZI	EN OF WHAT	
ER/	706 Holy Cross	Road				21225		U	S.A.	
BY FUNERAL DIRECTOR	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 1	VES 2 N		If yes, sp		NIC ORIGIN? (Specify an, Puarto Rican, etc.) by:		Black, Wh Specify:	
	15. DECEDENT'S EDUC	ATION	16a. DE	CEDENT'S US	UAL OCCUPATION	ON .	16h KIND OF	BUSINESS/INDU		White
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gi		k done durina mo		100.1000	DOGINEGONINDO		
PL	8th Grade	College (1-4 of 5 +)	Н	ousewi	fe		Home	Maker		
OM	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Middle, Mail			
	C	harles C	allifi	Lower		Ba	rbara E1	izabeth	h	
) BE	19a. INFORMANT'S NAME (Type/Print)		191	. MAILING A	DRESS (Street a	nd Number or Rural	Route Number, City or	Town, State, Zip (Code)	
5	Marie Schultz		7	06 Ho	ly Cros	s Road	Baltimo:	ce, Mar	yland	21225
	20e. METHOD OF DISPOSITION 1 52 Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val from Stata	20b. PLACE of cemetary, Balti	and date of crematory or MOLE	F DISPOSITION other place) Nationa	(Name	1	LOCATION — C		
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE		1	22. NAME A	ND ADDRESS OF FA	CILITY			a y Louis
	Hama M	Zrane	ious	shi			nce Funera Hwy. Bai			21225
	23. PART i. Enter tha diseases, or ct	melicationa that ca	used the da	ath. Do not						Approximate
	shock, or heart failure	ast only one cause o	on aach iine							interval Between Onset and Death
		Delaude	tion						İ	1 clay
ij	resulting in death)	Deling dra	AS A CONSE	DUENCE OF):					1	· cosecy
RTIFICATION	Sequentielly list conditions,	Congestion DUE TO (OR	AS A CONSE	TELLI	we					2WKS
AT	cause. Entar UNDERLYING	the state of								1 month
F	CAUSE (Disease or injury that initiated events	OUE TO (OR	AS A CONSE	DUENCE OF):	(01)					(00004
	resulting in death) LAST	Atheros	lest	ic c	alus	Nonwher	- Direc	H		
CE	DART II Other significant conditions		ah haa aa	1.1			I		1	
MEDICAL	PART ii. Other significant conditions	contributing to dea	ith but not r	esuiting in	tne undanyin	g cause given in		AN AUTOPSY FORMEO?	AVA	RE AUTOPSY FINDINGS ILABLE PRIOR TO
ă							1 🗆 YE	2 D NO		MPLETION OF CAUSE DEATH?
Z									10	YES 2 NO
ä										
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		- 1	26. P	LACE OF DEATH (C	heck only one)			
PHYSICIAN:		1 Inpetient 2 ER			☐ Nursing Hon		8 Cher (Specify)			
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJ (Month, Day, Y		28b. TIME (ty wo	URY AT DRK? YES 2 NO	28d. DEŞCRIBE HO	W INJURY OCC	URED	
	3 Suicide 8 Could not be	28e. PLACE OF IN building, atc.	JURY — At ho (Specify)	me, farm, str	et, factory, offic		281. LOCATION (Str City or Town, S		or Rural Route	Number,
TED	4 Homicide determined									
PLETE	20 2000	DAN: To the best of my	knowledge, de	eath occurred	at the time, date	and place, and du	e to the cause(s) and	manner sa state	d.	
COMPLETE										d menner as stated.

	- Commoditing to death but no	- I resulting in the C		PERFORMEO? 1 YES 2 (1) 40	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO	HOSPITAL: 1 Inputient 2 ER/Outputient	3 DOA 4 N	26. PLACE OF DEATH (Che ER: ursing Homa 5 & Raaldence		
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCU	URED
3 Suicide 8 Could not be	28e. PLACE OF INJURY — At building, atc. (Specify)	home, farm, street, fa	ctory, office	281. LOCATION (Street and Number of City or Town, State)	or Rural Route Number,

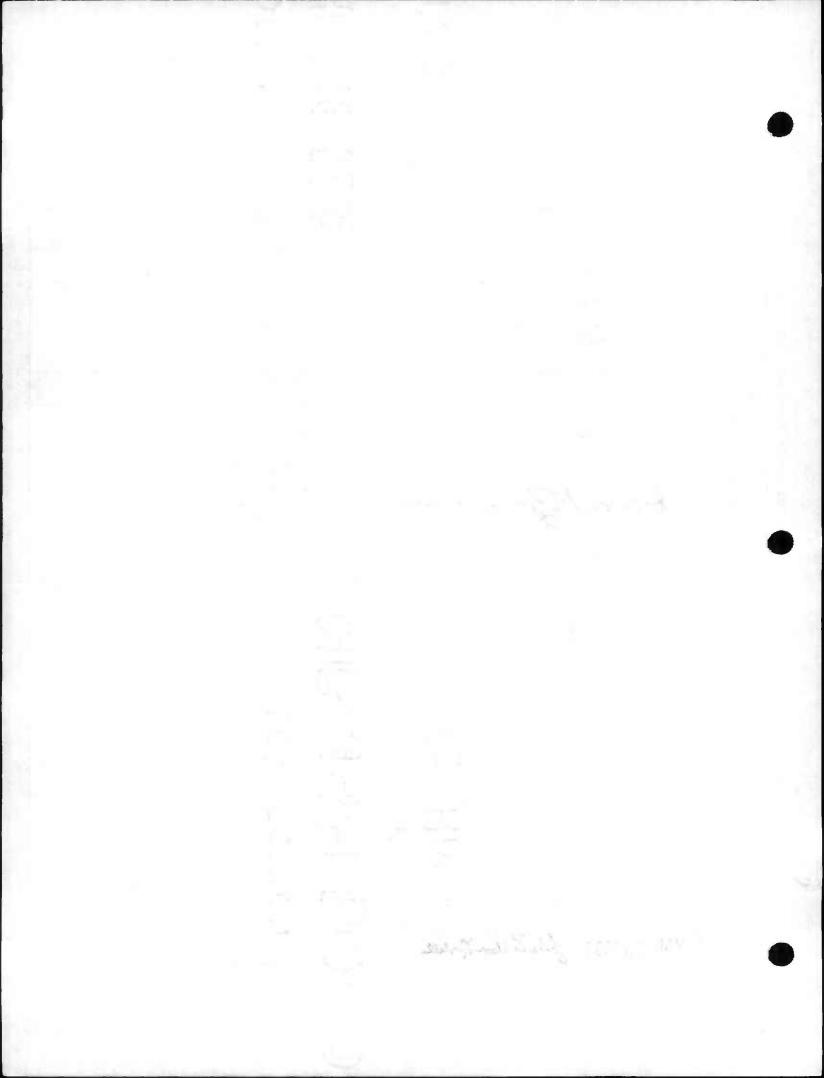
But	D39640
ME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Fine Print)	

30. N/ bulturie 212 30

29d. DATE SIGNED (Month, Day, Year)

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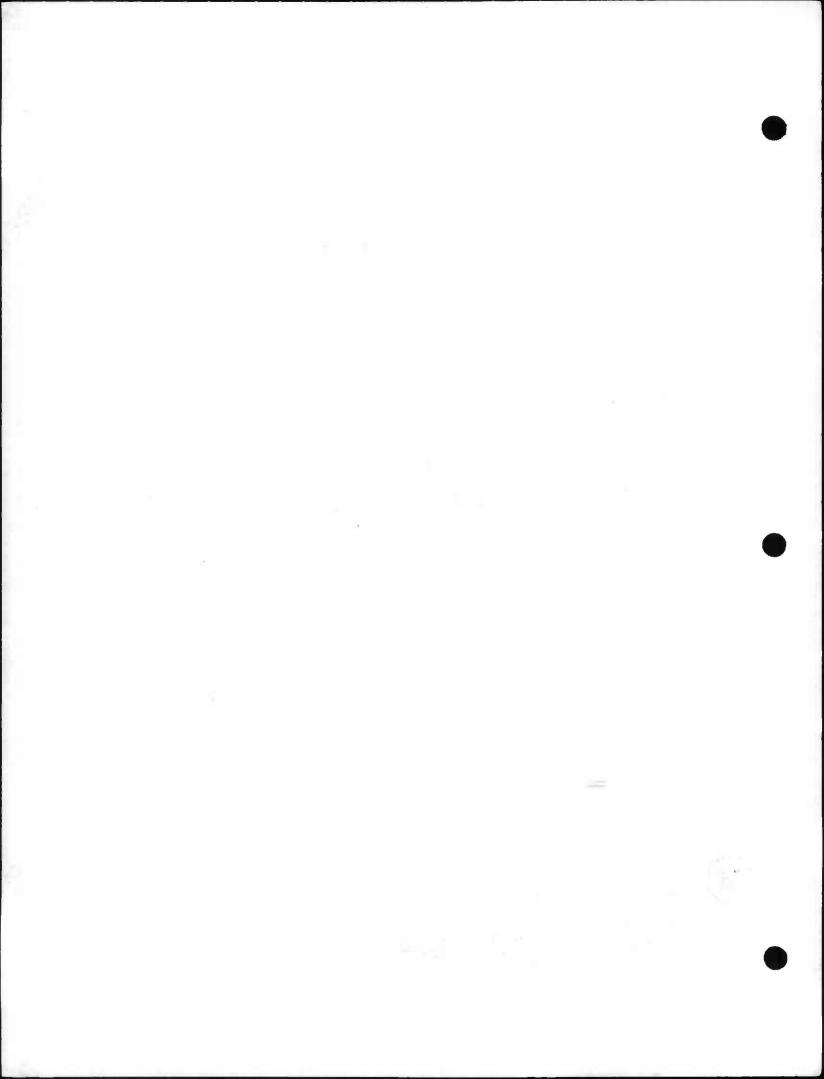
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93-1578-510 blh ITEMS: 23 PART I,27, 28a-f, PER MEO 4/14/93 t.t

		FOR 1 - STATE REGISTRAR	STATE OF MARY	YLAND / I	DEPAR RTIF	TMENT OF I	HEALTH AND	MENT	AL HYGIEN REG. NO		0	8589
		1. DECEDENT'S NAME (First, Middle, Last)		-				2. DAT	TE OF DEATH	ay ,	YEAR 3.	TIME OF DEATH
		TOVE	Α.			ashing	ton		3 2)341 M
				GE (In yrs. lest i		MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mo	E OF BIRTH nth, Day, Year)		. BIRTHPLI Country)	ACE (State or Foreign
Pin		215-72-2351 9a. FACILITY NAME (If not institution, give st	1 🕅 M 2 🗆 F	34	YRS.				2-25-5			ID
. 2, 3 should	RECTOR	1676 Darley Ave	at the control			Balti	MOTE	EATH		9c, COUNT	Y OF DEAT	н
ges 1,) E	10a. STATE 10b. COUNTY	,		10c. CIT	Y, TOWN OR LOCA	TION				10	d. INSIDE CITY
permit. Pages	□	MD 100. STREET AND NUMBER			Ва	ltimore	of, ZIP CODE			10a CITIZE		LIMITS? X YES 2 NO T COUNTRY?
100	FUNERAL	4133 Raymonin A				2	21213			US		COUNTRY
the hospital or attending physician, detached for use as the burial-tran	BY	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1/2 YE IF YES, GIVE WAR OR	R IN U.S. ARM ES 2 NO R DATES	ED)	If yes, sp	CENDENT OF HISPAI Decify Cuben, Mexica S 2 NO Specific	ın, Puerte	ilN? (Specify Yes o Ricen, etc.)	or No- 14	Black, W Specify:	American Indian, hita, atc.
al or attentor use a	ETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +)	(Give	s kind of v	USUAL OCCUPATI work done during me retired.)	ON ost of working	16	Sb. KIND OF BUS	SINESS/INDUS		
he hospita detached once,	COMPL	12th							City ()f Ba	1 tim	ore
the hospit e detached	8	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA					
क विद	BE	William Antho	ny Wilson						Washir			
s sho	인	190. INFORMANT'S NAME (Type/Print) Edna Washingto	n				and Number or Rural					213
ector, page	3	20a, METHOD OF DISPOSITION 1 IZ, Burlet 2 Cremetion 3 Remo	oval from State	20b. PLACE AN	IDDATE	proisposition (Na	ame of		TE 20c. LO	CATION — CH	y or Town,	Slata
. Page 6 ral directo		21. SIGNATURE OF FUNERAL SERVICE LIC		1 01 101			NO ADDRESS OF FA	CILITY	Ιυα	1 6 1 1110	,	טויו
the funer wal.	1	Fre	17			WM C.	. MARCH	F.	H./110)1 E.	NOR	TH AVE.
24 hours filled in to on, or re		23. PART I. Enter the disease, or c ehock, or heert feliure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	bmplications that cause on	INIO	XIC	ATION	ode of dying, suc	h aa ce	rdiac or reepi	ratory arrea	it,	Approximate interval Between Onset and Death
leath certificate be executed within attending physician and completely mal Hygiene prior to burial, cremating, or other traumatic event, if	CATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS			<u> </u>						
th certificate ending physical Hygiene pr	ERTIFIC	CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS	S A CONSEOU	ENCE OF	7):						
0 0 5	2	PART II. Other aignificant conditions	contribution to death	- hut		- 4 - 1 - 1			1			
requires that the signed by of Health and shows any i	: MEDICAL	againean commun	commouning to death	T DUT HOT FEE	solding i	n the underlyin	g ceuse given in	Part I.	24a. WAS AN PERFOR 1 YES 2	MED?	AMR COI OF	RE AUTOPSY FINDINGS IRLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
hass De De	IAN:	25. WAS CASE REFERRED TO MEDICAL				28. PI	LACE OF DEATH (Ch	eck only	onel		L	
SICIAN: The certificate h the State I	SICI	EXAMINER?	HOSPITAL:	utpatient 3	DOA	OTHER:	ne 5 A Residence					
PHYSICIAN: this certifical with the St inked, or it	PHY	27. MANNER OF DEATH	28a. DATE OF INJUR		28b, TIMI	E OF 28c. INJ	JURY AT		ESCRIBE HOW II	NJURY OCCUP	RED	
DING PHYS After this death with	ВУ	1 Natural 5 Pending 2 Accident Investigation	3 - 25 - 93	<i>'</i>	UNI		YES X NO	IINI	KNOWN			
TTENDII TOR: A after de	TED	3 Suicide Could not be determined	28a. PLACE OF INJUI building, etc. (So FOUND	PRY — Al home pecify)		treet, factory, offic	4	28f. LO	CATION (Street a y or Town, State)	1676	Dar	ley Ave.
DIREC DIREC hours	PLE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	SAN: To the beat of my kno			d at the lime, date	and place, and due				rvla	n a
DESPITAL DESPITAL DESPITAL	W 0	2 (XMEDICAL EXAMINER	t: On the basia of examinat									d manner as stated.
英 在 每 2	SE.	SIGNATURE AND TITLE OF CERTIFIER	. ll				29c. LICENSE NUI	MBER		29d. DATE S	IGNED (Mo	nth, Day, Year)
B B #	0	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE ST	DEATH ATT	0.TD .CT	Diret	O.C.M	.E.		03	25	1993
		HAMADRIND 1.160	RELL W	111			eet, Ba	lti	more,	Mary	Land	21201
		MAR 3 0 1993	The Dands	A- Aland	12							



93 08590

	1. DECEDENT'S NAME (First, Middle, L	Last)		<u>-</u>				H 2.	DATE OF DE			3. TIME OF DEATH
	CHANTE	SHIRE			WI	LS	ON		монтн 0 3	24	93	7:00 a
	4. SOCIAL SECURITY NUMBER 214-08-2290	5. SEX	6. AGE (In yrs. lest bi		IF UNDER 1	YEAR DAYS	HOURS		Month, Dev.	Year)	8. BIRTI	HPLACE (State or Foreign
	9a. FACILITY NAME (If not institution, §		2)		b. CITY, 1	TOWN OF	R LOCATIO	ON OF DEATH	11-0	7-67	DUNTY OF D	DEATH
OR O	1500 BLK.N.R	OLLING RO	DAD									ORE COUNT
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. CO		1	10c. CITY, T	TOWN OR	LOCATI	ON					10d. INSIDE CITY
뚭	MD	Columbia										LIMITS?
RAL	104. STREET AND NUMBER	Tama Ama		01			ZIP CODE			10g. C		WHAT COUNTRY?
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BY	1 Never Married 2 Married 3 Wildowed 4 Divorced		YES 2 NO		11 1	yes, spe	cify Cuber 2 NO	i, Mexican, Pu	ierto Rican, a	itc.)	Blac Spec	k, White, atc.
TED	15. DECEDENT'S (Specify only highest of		(Glve	DENT'S US kind of work NOT use re	rk done du	CUPATION wing most	N t of working	9	16b. KIND	OF BUSINESS/I	NDUSTRY	
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5	*)	one	ourou.)					Vone		
CO	17. FATHER'S NAME (First, Middle, Last	1)					18. MOTH	ER'S NAME (Meiden Surname)	
BE	Junius Mack 190. INFORMANT'S NAME (Type/Print)	Wilson	Line	These .	Harris.		_	-		ne Gil		
2	Minnie Rogen	e Rall	196. N							or Town, State,		21207
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3	es	20b. PLACE AND	DATEOF	DISPOSIT	ION (Nan	•	рал	OATE 2	Oc. LOCATION	— City or To	own, State
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVIC		cometery cremate King	Memo				3/29,	/93 I	Balto.	Co.	, MD
5	Maggales	6 11	1Jen		S OT	1 FI	uner	al Se	ervi	galean ge c/c	Cha	more Hen- itman-Harr
	23. PART I. Enter the diseases, shock, or heart fells	or complications the	it coused the deet	n. Do not		1 H	ome		McCi	respiratory		Approximata
FICATION	immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	a	or coused the deeth use on each line. TIPLE OR AS A CONSEQUE	ENCE OF):	enter ti	he mod	ome le of dyli		McCi			
: MEDICAL CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	a	TPP (OR AS A CONSEQUE (OR AS A CONSEQUE (OR AS A CONSEQUE	ENCE OF):	JW	he mod	ome le of dyli	ng, such as	MC Cl cardiac of		arrest,	Approximata Interval Between
: MEDICAL CE	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant cond 25. WAS CASE REFERRED TO MEDICA EXAMINER?	a. DUE TO b. OUE TO c. DUE TO d. HOSPITAL:	It coused the deet use on each line. The couse of the co	ENCE OF):	THE UNITED	1 H (he mod	cause g	lven in Part	MC Cr cardiac or	WAS AN AUTOPS ERFORMED? YES 2 NO	Y 24b	Approximate Interval Between Onset end Death Death Onset end D
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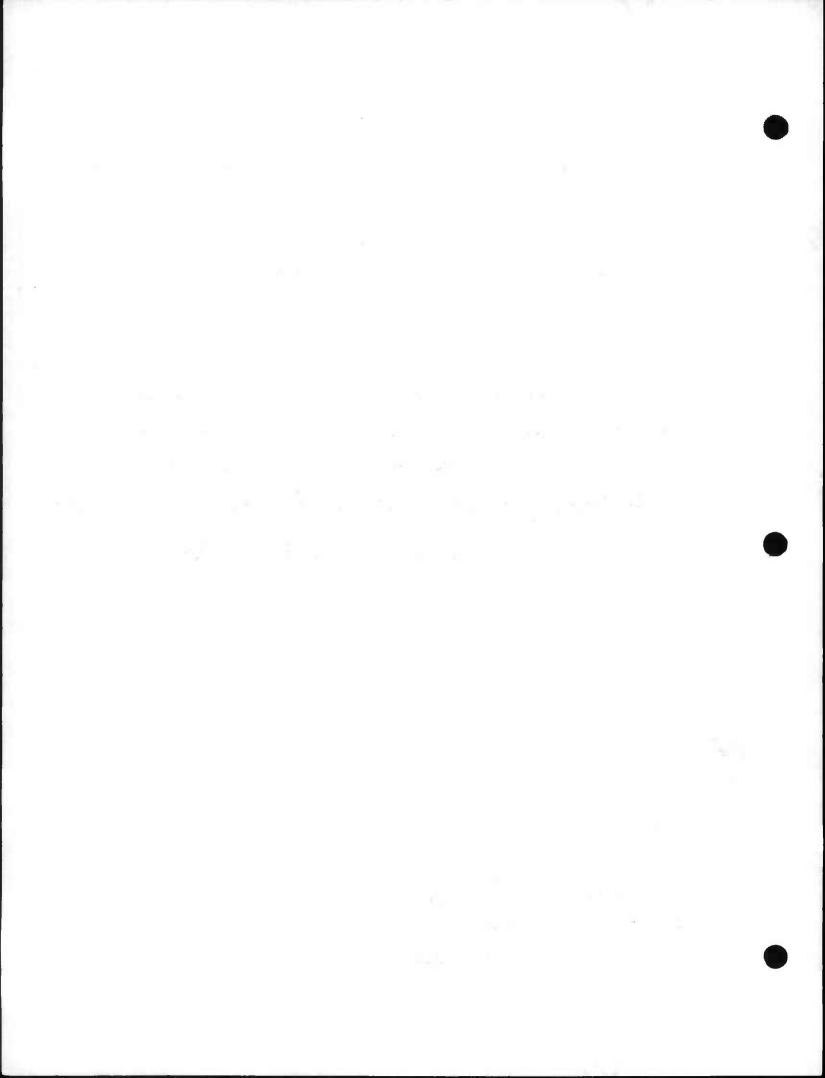
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

24 hours after death. Page 6 may be retained by the hospital or atten	hiled in by the funeral director, page 5 should be detached for use as on, or removal.	ne medical examiner must be notified at once.	TO BE COMPLETED
TO THE HOSPITAL OR ATTENDING PRESIDENT The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attend	10 THE FUNEMAL OFFICIAL MENT OF THE TOWN TO BE SIGNED BY THE ATTENDING PRYSICIAL AND COMPIETELY MINED IN DRY THE TUNEMAL DIRECTOR, page 5 should be detached for use as be filled within 7 hours after death of the part and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is married to the more and the married shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSIMAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

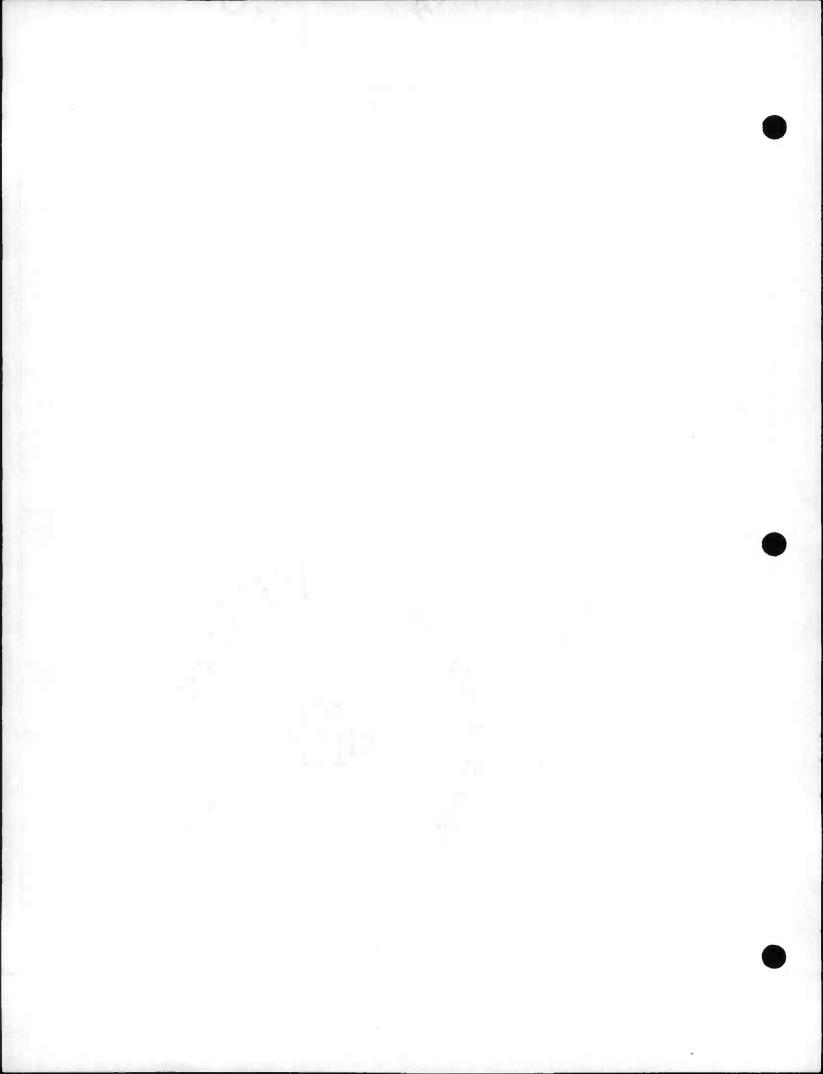
	1. DECEDENT'S NAME (First	t, Middle, Lest)								2. DATE OF OEA			3. TIME OF DEATH
	HENRY	W.	W.	LLIAM		YOU	NG	JR.		03 2	1 19	93	10:38 AM
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. less	birthday)	IF UNDER	1 YEAR	IF UNDER		7. DATE OF BIRT	1	8. BIRT	HPLACE (State or Foreign
	217-50-7	689	1 🔀 M 2 🗌 F	42	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Dey, Ye 6/26/1		Court	ryland
	9a. FACILITY NAME (If not in	nstitution, give s	treet and number)			9b. CITY,	TOWN (R LOCATIO	ON OF DE			UNTY OF E	
DIRECTOR	14 MARGAR	ET AV	Έ.			PA	SAD	ENA	_		AN	NE A	ARUNDEL
E	RESIDENCE OF DEC	10b. COUNTY	7		10c. CITY,	TOWN O	R LOCAT	ION					10d, INSIDE CITY
E	Maryland	Anı	ne Arunde	21	Pa	sade	na						LIMITS? 1 YES 2 TO NO
	10e. STREET AND NUMBER						101	. ZIP CODI	E .		10g. C	TIZEN OF	WHAT COUNTRY?
FUNERAL	14 Margar	et Ave	enue					211	122			U.S.	Α.
2	11. MARITAL STATUS 1 Never Married 2	7.84	12. WAS DECEDER	T EVER IN U.S. ARI	MED	13. \	MAS OEC	ENDENT O	F HISPAN	IC ORIGIN? (Speci	y Yes or No-	14. RAC	E — American Indian, ik, White, atc.
Æ	3 Widowed 4 Dive			WAR OR DATES				2 NO			•,	Spec	elfy:
		EDENT'S EDU		18a, DE	CEDENT'S U	JSUAL OC	CUPATIO			16h KINO O	BUSINESS/II	UNIISTRY	White
	(Specify oni	ly highest grade 0-12)	completed) College (1-4 or 5	(Gi	ve kind of wo Do NOT use	ork done o	furing mo	st of workin	g	TODA TANCO O	500111230/11	NO OTHI	
COMPLETED					orker					Fed	eral G	oven	nment
S	17. FATHER'S NAME (First, M							18. MOTH		NE (First, Middle, M	,		
BE			Henry W.							en Barb			t
2	Raymond Li	,	1							loute Number, City o			
	20a. METHOD OF DISPOSIT		ıaı	20b. PLACE A	06 Di					Pasadena	LOCATION -		
	1 St Buriel 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	on 3 Ram	oval from Stata	cemetery, crer Wood1	natory or oth	er place)							
	21. SIGNATURE OF EUNERA	L SERVICE LIC	ENSEE		uwii (22.1	NAME AN	D ADDRES	S OF FAC	alli y			Maryland
	· Um	na)	MS	amini	ne	40	org	e J. Ritcl	Gond	ce Funer Hwy. Ba	al Hon	ne P.	A.
	23. PART I, Enter the d	Iseases, or	complications the	it caused tha de	ath. Do no	ot antar	tha mo	da of dyl	ng, auch	as cardiac or	eapiratory a	rreat,	d. 21225
- [ahock, or h IMMEDIATE CAUSE (Fig	aart fallure.	only one car	use on each line.									Intarval Between Onset and Death
	disease or condition resulting in death)	→	. M	1-1-tiple	و	(50	18	Lo	+ 0	cord)	5		
1			DUE TO	(OR AS A COUSEO	UENCE OF)	:			1 V				
NO	Sequentially list condit	ions,	b	(OR AS A CONSEC	UEVOE OF								
TĂ.	if any, leading to imme cause. Enter UNDERLY		DOE 10	(OR AS A CONSEC	UENCE OF)	12							i
E I	CAUSE (Disease or injuthat initiated events		C. DUE TO	(OR AS A CONSEO	UENCE OF)	:					<u> </u>		
CERTIFICATION	resulting in death) LAS	T L	d										
	PART II. Other significa	nt condition	a contributing to	death but not re	sulting in	the un	deriying	Cause o	iven in i	Port I 240 MM	S AN AUTOPS	/ 24b	. WERE AUTOPSY FINDINGS
5			_										
~ 1								, cadoo g		PE	RFORMEO?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
VEDI								, cadoo y		PE	RFORMEO?		COMPLETION OF CAUSE OF DEATH?
N: MEDICAL								, cadao y		PE			COMPLETION OF CAUSE
AN: MEDI	25. WAS CASE REFERRED T	O MEDICAL	MOSBITAL				26. PL			PE			COMPLETION OF CAUSE OF DEATH?
YSITAN: MEDI	EXAMINER?	O MEDICAL	HOSPITAL:	ER/Outpatient 3		OTHER	26. PL	ACE OF O	EATH (Che	— XXY	S 2 NO		COMPLETION OF CAUSE OF DEATH?
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BY PHYSIDAN	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 8 4 Homicide	Pending investigation Could not be determined	28a. OATE OF O 3 / 2 1 28a. PLACE Cobuilding,	INJURY Ay 1997 FINJURY — At her etc. (Specify)	28b. TIME 10 : 1	OTHER 4 Num OF RY 3 A	26. PL 1: ling Hom 28c. INJ WO 1 \\	ACE OF OI 5 57 Re URY AT RK?	EATH (Che	ck only one) 8 Other (Specify 28d. DESCRIBE H SUBJEC 281. LOCATION (S City or Town,	OW INJURY O	CCURED	COMPLETION OF CAUSE OF DEATH? XX YES 2 \(\text{NO} \) NO
BY PHYSIDAN	EXAMMER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 8 4 Homicide 29e. CERTIFIER (Check only)	Pending Investigation Could not be determined	28e. OATE OF O 3 Modify 28e. PLACE Coulding.	INJURY ay 1993 FINJURY — At horetc. (Specify) RESI my knowledge, des	28b. TIME 1NJU 10 • 3 ne, term, str	OTHER 4 Num OF RY 3 3 A Teet, factor	26. PL 1: ling Hom 28c. INJ WO 1 1 1	ACE OF OI 5 17 Re URY AT RK7 (ES 2	EATH (Che sidence I	ck only one) 5 Other (Specify 28d. DESCRIBE H SUBJE(281. LOCATION (S City or Town, 14 man(to the cause(e) and	DW INJURY O	CCURED TT er or Rural	COMPLETION OF CAUSE OF DEATH? X X YES 2 NO Route Number,
COMPLETED BY PHYSIDAN.	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 8 29e. CERTIFIER (Check only one) 2 MED	Pending Investigation Could not be determined	1 □ Inpettent 2 □ 28a. OATE OF 0 3 / 2 □ 28a. PLACE Of building. CIAN: To the best of R: On the best of e	INJURY ay 1993 FINJURY — At horetc. (Specify) RESI my knowledge, des	28b. TIME 1NJU 10 • 3 ne, term, str	OTHER 4 Num OF RY 3 3 A Teet, factor	26. PL 1: ling Hom 28c. INJ WO 1 1 1	ACE OF OI 5 To Re URY AT RK? ES 2 end place,	EATH (Che sidence is not only in the sidence is	ck only one) 5 Other (Specify 28d. DESCRIBE H SIIR.IF.(281. LOCATION (SCify or Yown, 14 marc) to the cause(e) and time, date and place	OW INJURY O	CCURED TO Formal Interest of Rural Interest of	COMPLETION OF CAUSE OF DEATH? XX YES 2 NO Route Number,
BE COMPLETED BY PHYSITAN:	EXAMMER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 8 4 Homicide 29e. CERTIFIER (Check only)	Pending Investigation Could not be determined	1 □ Inpettent 2 □ 28a. OATE OF 0 3 / 2 □ 28a. PLACE Of building. CIAN: To the best of R: On the best of e	INJURY ay 1993 FINJURY — At horetc. (Specify) RESI my knowledge, des	28b. TIME 1NJU 10 • 3 ne, term, str	OTHER 4 Num OF RY 3 3 A Teet, factor	26. PL 1: ling Hom 28c. INJ WO 1 1 1	ACE OF OI 5 A Re URY AT RK? YES 2 end place, eath occur 29c. LICE	EATH (Che sidence is not sidence is not sidence is not sidence is not sidence in the sidence in	ck only one) 5 Other (Specify 28d. DESCRIBE H SIIR.IF.(281. LOCATION (S City or Town, Id. mance to the cause(e) and time, date and place BER	OW INJURY O THE SHOT SHOT SHOT SHOT SHOT SHOT SHOT SHOT	CCURED T er or Rural i	COMPLETION OF CAUSE OF DEATH? X X YES 2 NO Route Number, a) and menner as stated. D (Month, Day, Year)
COMPLETED BY PHYSIDAN.	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 8 29e. CERTIFIER (Check only one) 2 MED	Pending Investigation Could not be determined CIFYING PHYSI ICAL EXAMINE OF CERTIFIER	28a. OATE OF O 3 Mooth 2 L 28a. OATE OF O 3 Mooth 2 L 28a. PLACE O building, CIAN: To the best of a COMPLETED CAU	INJURY Section 28b. TIME INJU 10 • 7 ne, term, str DENC with occurred investigation	OTHER 4 Nurs OF RY M 3 3 A reet, factor	26. PL 1: ling Hom 28c. INJ WO 1 1 1	ACE OF OI 5 A Re URY AT RK? YES 2 end place, eath occur 29c. LICE	EATH (Che sidence is not only in the sidence is	ck only one) 5 Other (Specify 28d. DESCRIBE H SIIR.IF.(281. LOCATION (S City or Town, Id. mance to the cause(e) and time, date and place BER	OW INJURY O THE SHOT SHOT SHOT SHOT SHOT SHOT SHOT SHOT	CCURED T er or Rural i	COMPLETION OF CAUSE OF DEATH? XX YES 2 NO Route Number,	
BE COMPLETED BY PHYSITAN:	EXAMMER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Accident 3 Suicide 8 Suicide 8 Medical Medical Suicide 8 Medical	Pending Investigation Could not be determined TIFYING PHYSI ICAL EXAMINE OF CERTIFIER	28a. OATE OF O 3 / 25 / 25 / 25 / 25 / 25 / 25 / 25 /	FINJURY — At hor etc. (Specify) MF S I my knowledge, des xamination and/or is SE OF DEATH (ITEM	28b. TIME 10 2 10 10 10 10 10 10 10 10 10 10 10 10 10	OTHER 4 Nurs OF RY 3 A Treet, factor FE if at the tin , in my of	26. PL	ACE OF OI o 5 12 Re URY AT RK7 /ES 2 end place, eath occur 29c. LICE	EATH (Cheese sidence of sidence o	ck only one) 5 Other (Specify 28d. DESCRIBE H SIIR.IF.(281. LOCATION (S City or Town, Id. mance to the cause(e) and time, date and place BER	DW INJURY O	CCURED OT er or Rural I ave inted. the ceuse(iXTE SIGNED 3 / 2 2	COMPLETION OF CAUSE OF DEATH? X X YES 2 NO Route Number, a) and menner as stated. D (Month, Day, Year)
BE COMPLETED BY PHYSITAN:	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 S Suicide 8 S Suicide 8 MEDICAL MEDICA	Pending Investigation Could not be determined TIFYING PHYSI ICAL EXAMINE OF CERTIFIER	28a. OATE OF 28a. OATE OF 28a. OATE OF 3 / 20 / 20 / 20 / 20 / 20 / 20 / 20 / 2	INJURY — At hor etc. (Specify) MF S I Try knowledge, des xamination and/or is	28b. TIME INJU 10 - 7 ne, term, sterm, sterm term, erm, sterm term, sterm term, sterm term, sterm term, sterm term, sterm term term, sterm term term, sterm term term term term term term term	OTHER 4 Nurs OF RY 3 A Treet, factor FE if at the tin , in my of	26. PL	ACE OF OI o 5 12 Re URY AT RK7 /ES 2 end place, eath occur 29c. LICE	EATH (Cheese sidence of sidence o	ck only one) 3 Other (Specify 28d. DESCRIBE H SUBJE(281. LOCATION (S City or Town, 1.4 marc to the cause(e) and tilms, date and place BER	DW INJURY O	CCURED OT er or Rural I ave inted. the ceuse(iXTE SIGNED 3 / 2 2	COMPLETION OF CAUSE OF DEATH? XX YES 2 NO Route Number, a) and menner as stated. 0 (Month, Day, Year) / 1993



DIVISION OF VITAL RECORDS,

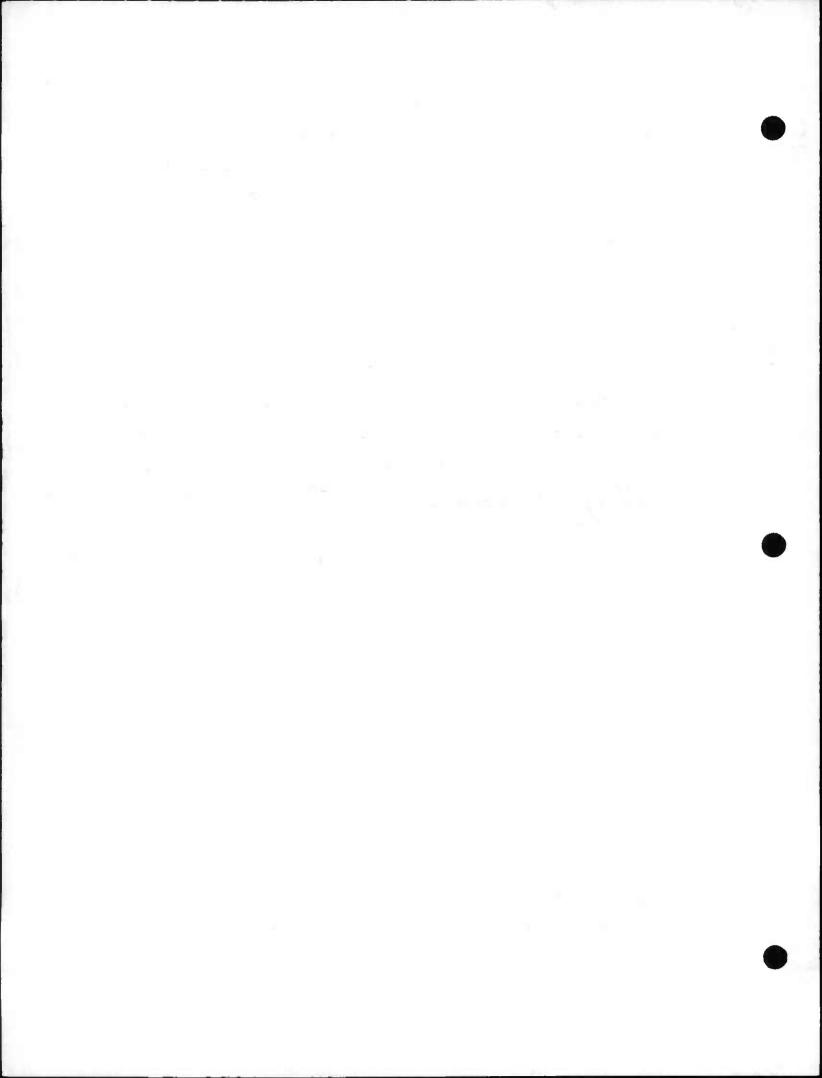
DALLIMONE, MAN TEAM ZETS-0020	MARYLAND ZX 15-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the more at	retained by the more and in physician.
TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be deather the burial-transit permit. Pages 1, 2, 3 should	s should be described to the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.)
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	otified at once.

	1 - STATE STATE OF MARYLA	AND / DEPARTMENT OF HEAL CERTIFICATE OF DE		33 00332
	1. DECEDENT'S NAME (First, Middle, Last) BESSIE C. YAI	VKELOV	2. DATE OF DEATH MONTH Z 6	3. TIME OF DEATH
2		n yrs. last birthday) IF UNDER 1 YEAR IF UN YRS. MONTHS DAYS HOUF	IDER 24 HRS. 7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign Country) MARYLAND
OR	9s. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL	96. CITY, TOWN OR LOC BALTIMORE	ATION OF DEATH	9c. COUNTY OF DEATH
DIRECTOR	10a, STATE 10b, COUNTY MARYLAND	10c. CITY, TOWN OR LOCATION BALTIMORE		10d, INSIDE CITY LIMITS?
FUNERAL D	10. STREET AND NUMBER 5519 PRICE AVE.	10f. ZIP C	.215	1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA
ВУ	11. MARITAL STATUS 1 Never Merried XX Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, OIVE WAR OR DA	U.S. ARMED 2 V NO II yes, specify C 1 VES 2 X	TT OF HISPANIC ORIGIN? (Specify Yes of Auben, Mexican, Puerto Rican, etc.) NO Specify:	or No— 14. RACE — American Indian, Black, White, etc. Specify: WHITE
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of we life. Do NOT use retired.) SALES		'S DEPT. STORE
BE CON	17. FATHER'S NAME (First, Middle, Last) ISRAEL MILLER	18. M	NOTHER'S NAME (First, Middle, Maiden S CELIA RO	Surname) OSEN
TO B	MRS. MICHAEL M. YANKELOV	19b. MAILING ADDRESS (Street and Num 5519 PRICE AVE.	nber or Rural Route Number, City or Town, BALTO., MD 2]	, State, Zip Code) 1215
	11. Burial 2 ☐ Cremation 3 ☐ Removal from State cem	PLACE AND DATE OF DISPOSITION (Name of etery, crematory or other place)	OATE 20c. LOC	ATION — City or Town, Stata FIMORE, MD
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	SOL LEVI	PRESS OF FACILITY INSON & BROS., IN INSTERTOWN RD. BA	NC.
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	the death. Do not enter the mode of	dying, such as cardiec or reapire	atory arrest, Approximate interval Between Onset and Death
MEDICAL	PART II. Other significent conditions contributing to death by DIABETES MELLITUS + TS(HEMIC HEMRT D SIP CABG, SIP,	YPE Z HTN PISENIE , CAD AV R	PERFORM 1 VES 2	MED? AMAILABLE PRIOR TO
BY PHYSICIAN:	25. WAS CASE REFERENCE TO MEDICAL EXAMINER? 1 VES 2 VO 1 Unpettent 2 ER/Outp 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident	attent 3 DDA OTHER: 28b. TIME OF NUJURY A WORK? NUMBER OF NUMBER	2 NO	
ETED	4 Homicide defarmined building, etc. (Spec	— Al home, larm, street, factory, office	26f. LOCATION (Street an City or Yown, State)	nd Number or Rural Route Number,
COMPLETED	29a. CERTIFIER 1 Check only 2 MEDICAL EXAMINER: On the best of my knowl			
TO BE (29b. SIGNATURE AND TITLE OF CERTIFIER M M M M M M M M M M M M M	UJESTAFF	LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) 3 26 9 3
	31. DATE FILED (MONTH), Day, Year) 31. DATE FILED (MONTH), Day, Year) 32. REGISTRAR'S SIGNI	D. SINAM HOSPI	TAN OF BAN	TIMONE, MP.



1 - STATE REGISTRAR

		REGISTRAR		CERTIFI	CATE OF	DEATH	REC	3. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE		3. TIME OF DEATH	_
			Charity	Ann	Alexa	nder	МОИЗ ТН		993 6:39p M	ı
P		4. SOCIAL SECURITY NUMBER N/A	1 🗆 M 2 💢 F		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIR (Month, Day,) 3-28-	1993	BIRTHPLACE (State or Foreign Country) Maryland	
2, 3 should	стоя	•a. FACILITY NAME (If not institution, give to THE JOHNS HOPKI				OR LOCATION OF D		9c. COUNTY	Y OF DEATH	
, , s	당	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	~	10- 077	TOWN OF LOOK					_
mit. Page	DIRE	Maryland 10e, STREET AND NUMBER	Baltimore	100. C114,	TOWN OR LOCA	Du	ndalk		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
an. ransit permit. Pages 1, 2.	FUNERAL	1907 Quentin Roc			10	H. ZIP CODE	1222		n of what country? Inited States	
The burner	BY	11. MARITAL STATUS 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	If yea, ap	CENDENT OF HISPA Decify Cuben, Maxic S 2 X NO Speci	an, Puarto Rican, a	iffy Yea or No— 14 tc.)	4. RACE — American Indian, Black, White, atc. Specify: White	
3.1	8	15. DECEOENT'S EDU (Specify only highest grade	ICATION completed)	16a. DECEDENT'S U	ISUAL OCCUPATI	ON set of working	16b. KIND (OF BUSINESS/INDUS		
MARYLAND 21, retained by the hospital or 5 should be detached for u outfilled at once.	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)		ork done during me retired.)	ost or working		N/A	W	
AND the hospil detached	8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, I			
MARYLAND e retained by the hospit 5 should be detached notified at once.	B	James Davren Ale 19a. INFORMANT'S NAME (Type/Print)	zxander	19b. MAILING /	ADDRESS (Street			zabeth F.		_
	임	Bridaette E. Fra	ınk		Duentin			Marylan		
IORE, e 6 may be ector, page		20a. METHOD OF DISPOSITION 1X Burial 2 Cremation 3 Rem	oval from State Cen	h PLACE AND DATE OF	EDISPOSITION /A	ame of	OATE 2	Oc. LOCATION — CIT		
MO age 6 direct		4 Donation 5 Other (Specify)	H	metery, cremetory or oth HOLLY HULL	<u>Cemet</u>	ery 3	/31/93	Middle	River, MD	
BALTIMORE 24 hours after death. Page 6 may filled in by the funeral director, pa on, or removal.		21. SIGNATURE OF FUNERAL SERVICE LI	E Real	†	Duda	Ruck Fu	neral Ho	me of Du	ndalk, Inc. aryland 21222	
B nours after d in by the or removal		23. PART I. Enter the diseases, or	complications that caused	d the death. Do no	ot enter the mo	ode of dying, auc	h as cardiac or	respiratory arrea	it, Approximate	-
		IMMEDIATE CAUSE (Final disease or condition resulting in death)	Liet only one ceuse on e	ATUR	itt	1			Interval Between Onset and Death	
P 20 0 8			OUE TO (OR AS A	A CONSEQUENCE OF):	:				100	1
Secu and and burnatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	A CONSEQUENCE OF):	:	1			(SMWS	>
ficate plays	FICA	Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	C. DUE TO (OR AS A	A CONSEQUENCE OF):	•					
T = 5 = 5	ERT	resulting in death) LAST	d							
Me de de		PART II. Other significent condition	ns contributing to death b	out not resulting in	the underlyin	g cause given in	Part I. 24a. W	AS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS	
that by any	DICAL						P	ERFORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE	
Sign Sign Sign Sign Sign Sign Sign Sign	MEC								OF DEATH?	
AL RE(he law requir s has been si e Dept. of H	A.	AT WAS CLOSE DEFENDED TO MENOLE							1	
et et e	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	LACE OF DEATH (C)				_
SICIAL Certific Certific Certification of the distance of the	PHYS	27. MANNER OF DEATH	1 Impatiant 2 ER/Outp 28s. OATE OF INJURY	28b. TIME	OF 26c. IN.	JURY AT		(y) HOW INJURY OCCUP	RED.	-
ON OP DING PHYS After this of death with	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	3-29	INJUI	RY WO	ORK? YES 2 NO				
ISIC TTENDI TTEN	G	3 Suicide 8 Could not be determined	28s. PLACE OF INJURY building, atc. (Spec	f — At home, farm, str cify)	reet, factory, offic	a	281. LOCATION (: City or Town,	Street and Number or State)	Rural Route Number,	
4 7 5 =	COMPLET	29a, CERTIFIER (Check only one) 1 CERTIFYING PHYSI	ICIAN: To the best of my	dadge, death occurred	at the time, date	and place, and dua	to the cause(a) ar	nd manner as atated.		Ť
HOSPITAL FUNERAL within 72 I	S	2 MEDICAL EXAMINE		e and/or investigation,	, in my opinion, o	death occured at the	time, data and pla	ca, and due to the c	cause(a) and manner as stated.	
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If I	TO BE	290. SIGNATURE AND THE OF SERTIFIED	1 ton	WD		29c, LICENSE NU	MBER	29d. DATE S	28 93	
	-	30. NAME AND ADDRESS OF PERSON WH	RUFO, M	P 1	others	Hope	INS.	11.05PI	TAZ	
		MAR 3 1 1993	32 REGISTRAR'S SIGN	ATURE Mandall						



1993

Q

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH 3 0 13 Md 3 8. AGE (In yrs, last birthday, BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS 7. DATE OF BIRTH M d 28 1 M 2 M F (00 use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILIT . NAME (If not institution, give stree 9b. CITY. TOWN OR LOCATION OF DEATH BALTO 4112 PAR RANDA DIRECTOR 1000 NQ RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 - YES 2 NO FUNERAL 10e. STREET AND NUMBER WHAT COUNTRY? RA HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried It yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: ВҰ 3 Wildowed 4 Divorced 15. DECEDENT'S EDUCATION COMPLETED 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade the funeral director, page 5 should be detached for Elementary/Seco College (1-4 or 5+) PACKSH BALTO . Public School 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Lewis notified at oh BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, 2 40 pe 20e. METHOD OF DISPOSITION
145 Buriet 2 Cremetton 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must | ROUIUS men. PK 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY entificate has been signed by the attending physician and completely filled in by the ithe State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. or Item 23 shows any Injury, or other traumatic event, the medical expenses. 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one spuce on each line. Approximata intarval Batween IMMEDIATE CAUSE (Final **Onset and Death** disease or condition resulting in daeth) an Cla DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditiona, DUE TO (OR AS A CONSEQUENCE OF)-If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPS PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF PEATH (Check only one) DIRECTOR: After this certificate hours after death with the State EXAMINER? OTHER: 1 TYES 2 1 - Inpetient 2 - ER/Outpetient 3 - DOA 8 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? MANT. If Item 28 is marked, 28d, DESCRIBE HOW INJURY OCCURED 1 Natural BY YES 2 🗌 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 3 Suicide Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end menner as stated. FUNERAL Igethin 72 I 2 MEDICAL EXAMINER: On the beele of *** d/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, 93 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 10219 South Dolfield Road Owings Mills, Maryland 21117 REGISTRAM IGHATE 31. DATE FILED (Month, Day, Year)

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

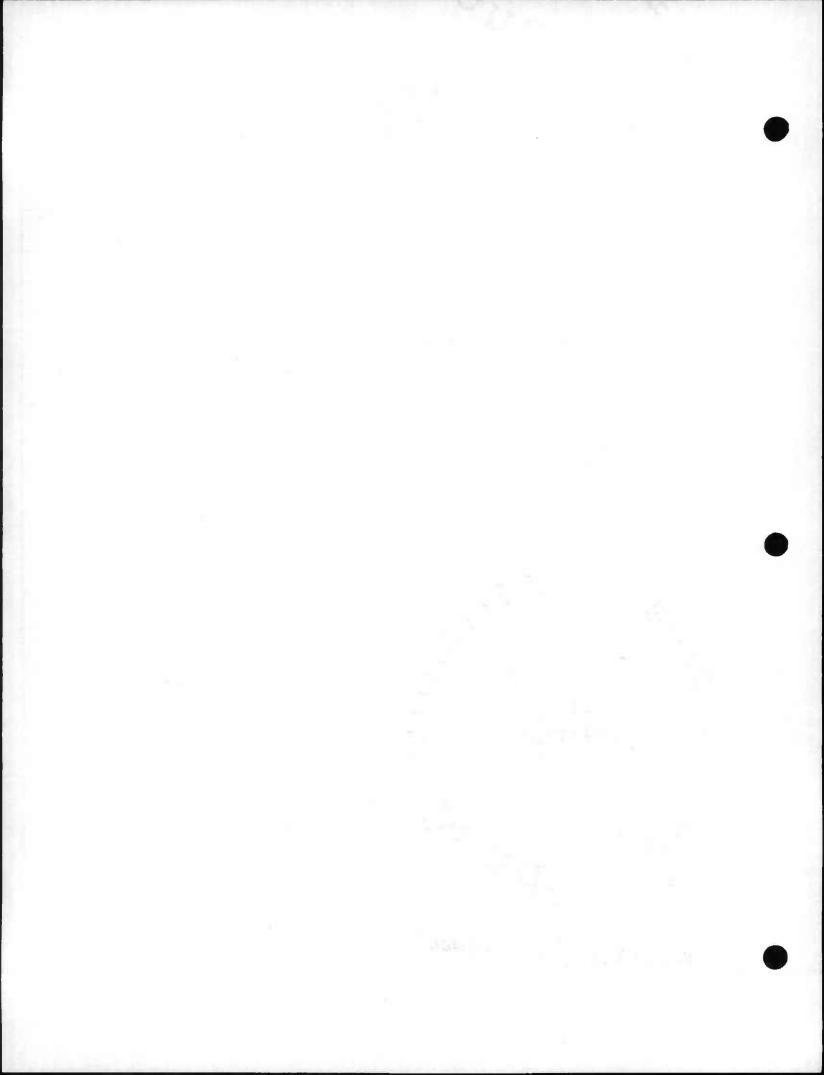
	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTME	NT OF HEALTH AND TE OF DEATH		HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF		3. T	IME OF DEATH
	ROSE W.	APOLITO			MARCH	1 24 1	993	8:20 P M
	4. SOCIAL SECURITY NUMBER 135-14-6101	1 🗆 M 2 📈 F	fin yrs. last birthday) IF UN MONTH	DER 1 YEAR IF UNDER 24 HRS. IS DAYS HOURS MIN.	7. DATE OF (Month, D. AUG. 4	BIRTH		CE (State or Foreign
TOR	90. FACILITY NAME (If not institution, give HEBREW HOME OF GI RESIDENCE OF DECEDENT			ROCKVILLE	DEATH		INTY OF DEATH	———— ЕRУ
DIRECTOR	10e. STATE 10b. COUNT	ONTGOMERY	10c. CITY, TOW	N OR LOCATION ROCKVILLE				INSIDE CITY LIMITS?
	10e. STREET AND NUMBER			101. ZIP CODE		10a, CIT	IZEN OF WHAT	YES 2 NO
FUNERAL	6121 MONTROSE ROA	1D		20852			U.S.A.	
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	3. WAS DECENDENT OF HISPA If yes, specify Cuben, Mexic 1 YES 2 NO Spec	an, Puerto Rica	specify Yes or No	14. RACE — A Black, Whi Specify:	merican Indien, ta, etc.
	16. DECEDENT'S EDI (Specify only highest grad	JCATION le completed	18a. DECEDENT'S USUAL	OCCUPATION	16b. KIP	OF BUSINESS/INC		ILIL
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	HOUSEWIF	•		OWN HOME		
Š	17. FATHER'S NAME (First, Middle, Last)				AME (First, Midd	le, Maiden Sumame)		
BE	MORRIS WEISS 19a. INFORMANT'S NAME (Type/Print)		105 MANUAL ADDR		EPSTEIN	•		
2	STEVE APOLITO			SS (Street end Number or Rural LEITH STREET				AND 20878
	20e. METHOD OF DISPOSITION		PLACE AND DATE OF DISP DISPLACED AND LEBAND	OSITION (Name of) N CEMETERY 3	/28/93	20c. LOCATION — ADFIPHT	City or Town, S	AND
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	2	2. NAME AND ADDRESS OF F	ACILITY	LI TUUTO	11 11010	7110
	Donald.	Stock	conger	2 NAME AND ADDRESS OF F. STEIN HEBREW 232 CARROLL	SIKEEI.	. N.W. WA	SHINGTO	:, INC. DN. D.C.
	IMMEDIATE CAUSE (Finel	e. Due to one sa Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa Sa	the desch. Do not entich iine.	er the mode of dying, aud	ch sa cerdlec	or respiratory an	rest,	Approximete Interval Between Onset and Daath
CERTIFICATION	Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	b. COROVA DUE TO (OR AS A		y DISCASE				
MEDICAL	PART II. Other algnificent condition	s contributing to death bu	it not resulting in the	undarlying cause given in		. WAS AN AUTOPSY PERFORMED?	AVAIL COMP OF DI	AUTOPSY FINDINGS ABLE PRIOR TO LETION OF CAUSE EATH? YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATH (C)	not and and			
ဗ္ဗ 📗	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpa	tient 3 DOA OTHI					
⋛∦	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIME OF	28c. INJURY AT		BE HOW INJURY OCC	CURED	
8	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WORK?				
	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY - building, etc. (Specif	At home, farm, street, fa	ctory, offica	261. LOCATION City or Tox	N (Street and Number wn, State)	or Rural Route N	umber,
COMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI	ICIAN: To the best of my knowle	dge, death occurred at the	time, date end place, end due opinion, death occured at the	to the ceuse(s)) end menner es state place, end due to the	ed. e cause(s) and r	nenner as stated.
H B	Alum A. The			29c, LICENSE NUI			E SIGNED (Mont!	
2	DO. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, Print) (0121 N	IONTROSE RE	: Ra	CKULLE	NO	26852
	31. DATE FILED (Month, Day, Year) MAR 3 1 1993:	32. HEGISTEAR'S SIGNA	note M2.		1			

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 9 3

	FOR STATE REGISTRAR	STATE OF MARYLAN		TMENT OF H		ENTAL HYGIENI REG. NO.	93 (10110
	1. DECEDENT'S NAME (First, Middle, Last) FRED		AD.	AMS		DATE OF DEATH DA	Y YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 190-05-1704	1√X M 2 □ F 91	s. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 7-24-1901	Co	ATHPLACE (State or Foreign Unitry)
TOR	9a. FACILITY NAME (If not institution, give s Fallston Gen. H			Fall	Ston	`H	Harfo	
DIRECTOR	MC .	_	10e. CITY	, TOWN OR LOCAT	Baldw	in		10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL		Lewis Rd.			21013		U	F WHAT COUNTRY?
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 N Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 ☐ YES 2 IF YES, GIVE WAR OR DATES	Kyo	If yes, spe	ENDENT OF HISPANIC ecity Cuban, Mexican, 2 NO Specify:	ORIGIN? (Specify Yes Puerto Rican, etc.)	. 8	ACE — American Indian, leck, White, etc. pecify: White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	Give kind of white. Do NOT us	USUAL OCCUPATION OF PORT OF PORT OF PART OF PORT OF PART OF PA	IN st of working		mess/moustragerton	
BE COM	17. FATHER'S NAME (First, Middle, Last)	John Quinsey A			18. MOTHER'S NAME	(First, Middle, Maiden		101130
10	19a. INFORMANT'S NAME (Type/Print) Mrs. Thelma E.		670	9 Lewis	Rd. Bald		21013	
	20e. METHOD OF DISPOSITION XX Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Spec/ly) 21. SIGNATURE OF FUNERAL SERVICE LIC	oval from State Gard	CEAND DATE OF COMMENTS OF COMMENTS OF		Demetery	3-30-93	Rossvi	
	▶ E. J. Lass	ahn		11750	Belair R	E.F.La d. Kingsvi	ille, M	Funeral Home d. 21087
ATION	iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditione, if any, leading to immediate	a. End Stag DUE TO (DR AS A CO	NSEQUENCE OF	goslin	e hears	- faile	ue	Approximate interval Betwee Onset and Dear
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Accular ducare. Caute Respectatory facilities.							
N: MEDICAL	PART II. Other significent condition Wy aseu Denile	a contributing to death but r	ach	n the underlying	Most	1 U YES 2	MED?	24b. WERE AUTOPSY FINDING AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Impatient 2 ER/Outpatient	nt 3 🗆 DOA	OTHER:	ACE OF DEATH (Check			
ВУ РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	26b. TIMI INJ	URY WO	URY AT RK? ZES 2 NO	8d. DEȘCRIBE HOW IN	JURY OCCURED	
ETED	3 Suicide 6 Could not be determined	28s. PLACE OF INJURY — J building, atc. (Specify)	At home, farm, a	treet, factory, office		8f. LOCATION (Street a City or Town, State)	nd Number or Rur	al Floute Number,
COMPL	0/10) 2 MEDICAL EXAMINE	CIAN: To the best of my knowledge R: On the basis of exemination and						e(e) end menner as stated.
TO BE	296. SIGNATURE AND TITLE OF CERTIFIES 30. NAME AND ADDRESS OF PERSON WH	DELLI CLUBO	(ITEM 27) (Turns	Print).	29c. LICENSE NUMB	18779	· 3/	26 / 93
	albert S. C. S 31. DATE FILED (Month, Day, Year)	UN, MD.	1800	// ~ /	ord Rd	Fallst	n M.	D 21047
	MAR 0 1 1993 4	133 REGISTRAL'S SIGNATU	٤					

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020



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BALTIMORE, MARYLAND 21215-0920

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60,	within	npletely
DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	TAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24	TAL DIRECTOR; After this certificate has been signed by the attending physician and completely find to have after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation
3	pe ea	cian a
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5	Certi	nding Hygie
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Alan B. Cohen, M.D.

MAR 3 1 1993

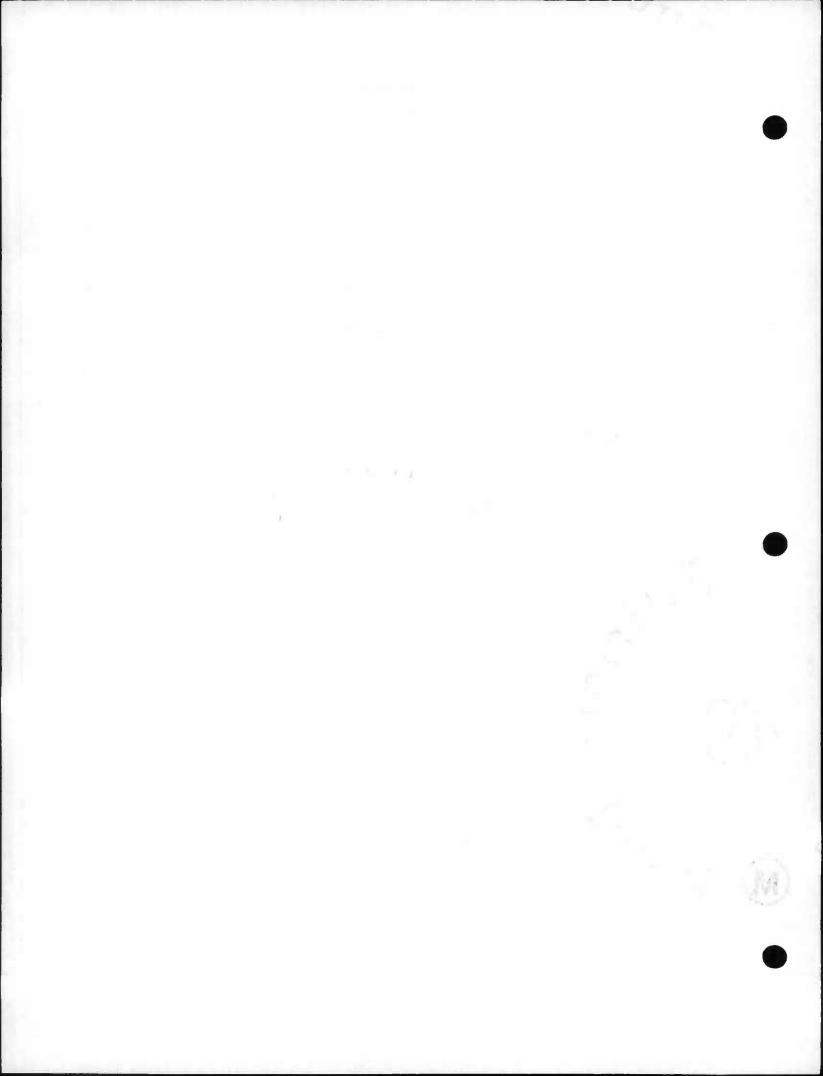
31. DATE FILED (Month, Day, Year)

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH March 29, 1993 YEAR JOHN STERLING BUSICK, SR. 11:10 A. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH
(Month, Day, Year)
Dec. 27, 1906 IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 86 DAYS HOURS 705-09-1381 1 XM 2 | F YRS. Maryland 9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 3304 Lerch Drive DIRECTOR Baltimore City RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY Maryland Baltimore City 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3304 Lerch Drive 21214 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married YES, GIVE WAR OR DATES BY 3 🕅 Widowed 4 🗌 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 B & O Railroad Supervisor be notified et once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sterling Price Busick Lucy Liebeman BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Floute Number, City or Town, State, Zip Code) 2 3304 Lerch Drive Baltimore, Maryland 21214 Mrs. Betty L. Brown 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must Baltimore Cemetery 4 Donation 5 Other (Specify) 4/1/93 Baltimore Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICE 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road 21214 medical 23. PART I. Enter the diseases or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Bety **IMMEDIATE CAUSE (Fine) Onset and Death** the disease or condition ulmma resulting in death) or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): hence PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST shows any injury, PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMEO? 1 | YES 2 | NO OF DEATH? 1 YES 2 NO Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) tem HOSPITAL: OTHER: 1 YES 2 4 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. OEȘCRIBE HOW INJURY OCCUREO marked, 1 Natural 5 Pending investigation M 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 69 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 28 1 CENTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. MPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and memor as stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE (29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) 36 30 10 3 93 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

Union Memorial Hospital Suite 501

32 REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

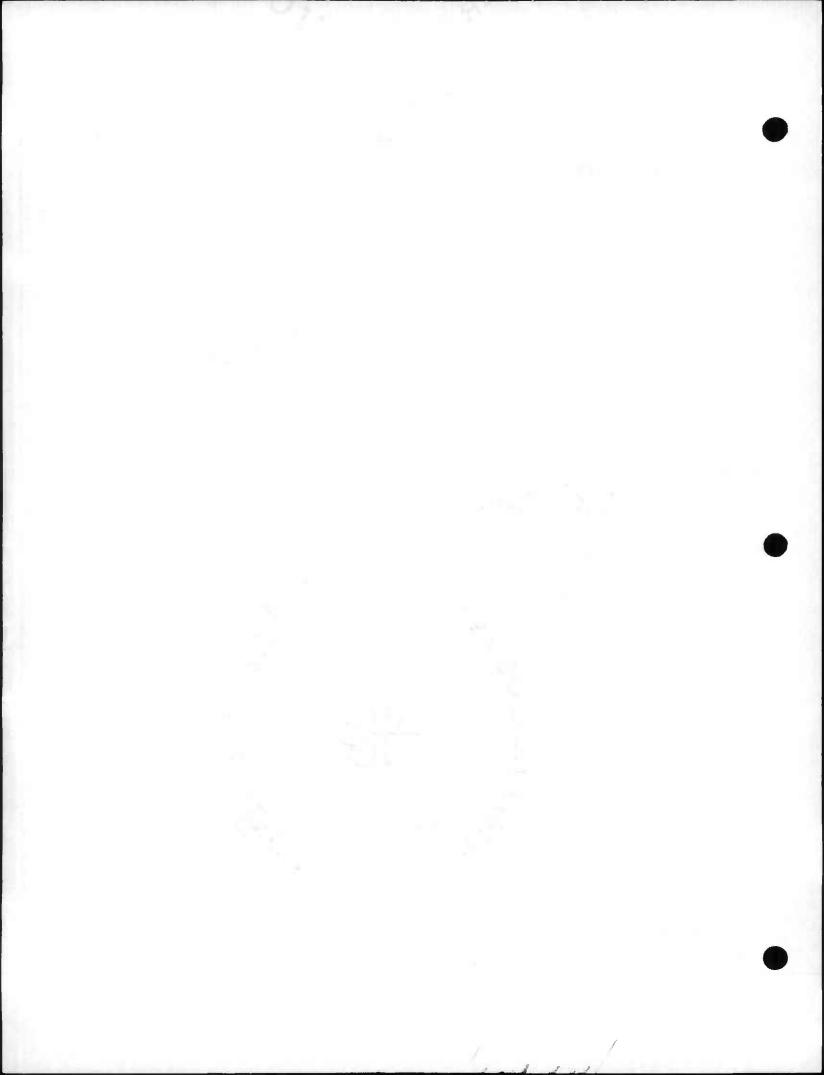
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGIS	
HEGIS	11
1. DECEDENT	14
4. SOCIAL SI	EC
186	2
MEMO RESIDENO 10a. STATE	F
Mary	7.
10e. STREET	A
702	ς
702 11. MARITAL 1 Never N 3 Wildows	Sile d
Elementar	
17. FATHER'S	N
John	n
19a. INFORM/	NA
Barb	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. RAR

1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH 3. TIME OF DEATH				1	
		MARY	Virgi	nia	BEI	LL				0 3	25	1	9 9 3	1813	Ри
	4. SOCIAL SECURITY NUME	ER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER	1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF	BIRTH		8. BIRTI	IPLACE (State or For	eign
- 9	186 20 26	79	1 - M 2 - KF	99	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Di	ny, Year) -189	2	Count		
	9a. FACILITY NAME (If not in		reet and number)			9b. CITY	, TOWN	OR LOCAT	ION OF DE		100		INTY OF D	nna	{
NO B	MEMORIAL H	OSPITA	Τ.			C	LIMB	ERL	AND					EGANY	
DIRECTOR	RESIDENCE OF DEC	EDENT													
2		10b. COUNTY			10c. CIT	Y, TOWN	OR LOCA	TION						10d. INSIDE CITY LIMITS?	- 1
	Maryland	Alle	egany Cou	ınty		Cuml								1 TYES 2 T	NO .
FUNERAL	10e. STREET AND NUMBER	Alleg	any Nur	Hm			10	f. ZIP COI	DE			10g. CIT	IZEN OF	WHAT COUNTRY?	
Ä	702 Queen	City 1								U			USA		
5	11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	TEVER IN U.S.						IIC ORIGIN? (S n, Puerto Rica		or No-	14. RAC Blec	E — American India: k, White, etc.	n,
BY	3 Widowed 4 Divorced IF YES, GIVE WAR OR DATE							Specify				Spec	White		
	15. DEC	CATION	16a.	DECEDENT'S	USUAL O	CCUPATI	ON		16b. KIP	ND OF BUS	INESS/IN	DUSTRY	WILLE		
COMPLETED	(Specify only highest grade completed) Li Elementary/Secondary (0-12) College (1-4 or 5+)					(Give kind of work done during most of working life, Do NOT use retired.)									
릴					Travel Agent				American Express			S			
Š	17. FATHER'S NAME (First, M	iddle, Last)		- 15-				18. MO	THER'S NA	ME (First, Midd	le, Maiden	Sumame)			
BE	John Bell					Barbara Miller									
6	19a. INFORMANT'S NAME (7	i/pe/Print)			19b. MAILING	ADDRES	S (Street I	and Numbe	or Aural I	Route Number, (City or Town	n, State, Zi	p Code)		
-	BarbaraPer	dew			507	Cent	ral	Ave	, Cur	nberla	nd.MI	215	502		
	20a. METHOD OF DISPOSIT		oval from State		CE AND DATE			ame of		DATE	20c. LO	CATION -	City or To	own, State	
	4 🕅 Donation 5 🗆 Other	(Specify)	1												i
	21. SIGNATURE OF THE NA	L SERVICE LIC	1 / White	ild Wad		22.	NAME A	ND ADDR	ESS OF FA	GLITY St	ateAr	nato	ny Bo	pard	
	Minn		1 pue	23/	29/93	65	5W.1	Balt	imore	St,Ba	alto,	MD 2	21201		
	23. PART I. Enter the di shock, or h	eart failure.	omplications the	saused the	death. Do i	not enter	the mo	de of d	ying, suc	h as cardlec	or respi	retory as	rest,	Approxima	
	IMMEDIATE CAUSE (FIR		K	och:	1		1	0						Onset and	
	disease or condition	→		C3/11/2	long	1	au	KY							
			DUE TO	(OR AS A CON	SEQUENCE O	f): //	Vo	0,0	Man						
CERTIFICATION	Sequentially list conditi		DUE TO	(OR AS A CON	SEQUENCE O	FI-	1"	000	111	Transport of the last of the l					\rightarrow
¥.	if any, leading to imme- cause. Enter UNDERLY	NG		(**************************************		,	,							İ	- 1
띮	CAUSE (Diseese or inju that initiated events	יא א	DUE TO	(OR AS A CON	SEOUENCE O	F):									
E	resulting in death) LAS	T													- 1
MEDICAL	PART II. Other significa	nt condition	s contributing to	deeth but no	ot moulting	in the ur	ndérlyin	g ceuse	given in	Part I. 24	PERFOR		248	. WERE AUTOPSY FIN AVAILABLE PRIOR T	
ă		6998	The H	Can 1	feeto .	10	(d	7.0		1	YES 2	NO		OF DEATH?	NUSE
Ä		1		U	2		-			_	/			1 - YES 2 - N	0
ÿ															
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:			OTHE		LACE OF	DEATH (Ch	eck only one)					
XS	1 YES 2 NO		1 Inpatient 2			4 🗆 Nur	sing Hon		lesidence	6 Other (Sc	oecify)				
	27. MANNER OF DEATH	Pending	28a: DATE OF (Month, D	injury lay, Year)	28b. TIM	URY	WC	URY AT ORK?	-30	28d. DEŞCR	BE HOW IF	VUURY OC	CURED		
à	2 Accident	investigation	280 DI ACE O	F INJURY AI	han to	М		YES 2	□ NO		The same of the sa				
		Could not be determined	building,	etc. (Specify)	nome, rerm,	street, ract	tory, onto	•		City or To	own, State)	ind Numbe	r or Rural i	Route Number,	- 1
<u> </u>	29a. CERTIFIER					_		_							
COMPLETED	(Check only		CIAN: To the best of												
8			1/ 1/	xamination and/	/or investigation	on, In my o	opinion, c	leath occu	red at the	Ilme, date and	i placa, an	d due to t	he cause(a) and manner as sta	ited.
H	290. SIGNATURE AND TITLE	OF CERTIFIES	1					29c. LIC	ENSE NUN	вен		29d. DA	TE SIGNED	(Month) Day, Year)	
ē I			3/14					D 1	9318				1/2	5/93	
- 1	30. NAME AND ADDRESS OF	Species	-			111111111111							1	1	
	N. RANJITHA	N M.D.	, 517 OI	DTOWN	ROAD,	CUMI	BERL	AND	MD :	21502			- 2		
	31. DATE FILED (MONTH, DON)	993	22. REGISTRA	H'S SIGNATUR	and .										



TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR

1. DECEDENT'S NAME (First, Middle, Last)	REGISTRAR CERTIFICATE OF DEATH REG. NO.									
	0	7	/		2. DATE OF DEATH		3. TIME OF DEATH			
LEONY	4 B.	DAVI	OR		3 2	Y 3-	M M			
4. SOCIAL SECURITY NUMBER	5. SEX 6. A	GE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN	8. B	IRTHPLACE (State or Foreign			
214-12-3835	1 M 2 K F	80 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)		ountry)			
9e. FACILITY NAME (If not institution, give str		00	at out y mount	00.00071011.00.00	10-10-1	9c. COUNTY	ARYLAND			
			WE. CITY, TOWN	OR LOCATION OF DE	AIN					
Merridian Cromwa	115					DAL	Timore			
RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY		100 00	TY, TOWN OR LOCA	TION			10d. INSIDE CITY			
		100. 0					LIMITS?			
	imore		ockeys				1 TYES 2 NO			
10e. STREET AND NUMBER			10	H. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?			
14108 CUBA H	4			2103	0	U	SA			
11. MARITAL STATUS	12. WAS DECEDENT EV				IC ORIGIN? (Specify Yes	or No- 14. 1	RACE — American Indien, Black, White, atc.			
1 Never Merried 2 Merried	FORCES? 1			pecify Cuben, Mexican S 2 🔀 NO Specify			Black, White, atc. Specify:			
3 Widowed 4 Divorced	,			opom,			Black			
15. DECEDENT'S EDUC	ATION	18e. DECEDENT'S	B USUAL OCCUPATI	ON	16b. KIND OF BU					
(Specify only highest grade of Elementery/Secondary (0-12)		(Give kind of life. Do NOT of	work done during muse retired.)	ost of working		0				
Elementery/Secondary (0-12)	College (1-4 or 5+)	Cleri	100		DALTI	nore	cunty Govit			
17. FATNER'S NAME (First, Middle, Last)		Cleri		I so MOTHERIN	ME (First, Middle, Melden	Cumpans'				
	hnson				0		_			
	11115011					hnson				
19e. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G AODRESS (Street	and Number or Rural F	Route Number, City or Tow	n, State, Zip Cod	9)			
Family Kecords	>									
20e, METHOD OF DISPOSITION 1 A Burlet 2 Cremetion 3 Remo	wel from State	20b. PLACE OF DISPO	OSITION (Name of co	emetery, crematory or		CATION — City				
4 Donation 5 Other (Specify)	THE TOTAL STATE	GOUGH M	etholis	- Cemet	ery Cox	Keysy	ille Md			
21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			ND ADDRESS OF FA	CILITY					
I O O O O	\bigcirc		EVAN	SChapel o	S Chimes Tinggium					
Gebert CV	Trover)	2329	YorkRd	TIMBIUM	Mg.	21093			
23. PART I. Enter the diseesea, or c ahock, or heert fellure. I			not enter the m	ode of dying, aucl	h ae cerdlec or reep	iretory errest,	Approximete interval Between			
IMMEDIATE CAUSE (Fine)	1						Oneet end Death			
disease or condition	Un terin	relevation	ONTMALL	contan.	2110011					
resulting in deeth)	DUE TO (OR	AS A CONSEQUENCE	OF):	a way	access to					
				,						
Sequentially list conditione,	OUE TO (OR	AS A CONSEQUENCE	OF):							
if any, leeding to immediate ceuse. Enter UNDERLYING										
CAUSE (Disease or injury that initiated events	OUE TO (OR	AS A CONSEQUENCE	OF):							
resulting in deeth) LAST										
	4									
			_							
PART II. Other eignificent condition	e contributing to dec	eth but not resulting	in the underlyle	ng ceuee given in			24b. WERE AUTOPSY FINDINGS			
		eth but not resulting	in the underlyle	ng ceuee given in	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE			
De	mentra	eth but not recuiting	in the underlyle	ng ceuee given in		RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
De		oth but not resulting	in the underlyle	ng ceuee given in	PERFO	RMED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE			
De C'	mentra	eth but not resulting			PERFO	RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
De	menter VA	eth but not resulting	26. [ng ceuee given in	PERFO	RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
De C' (25. WAS CASE REFERRED TO MEDICAL	mentra		26. I OTHER:		PERFOI 1 YES :	RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1 Inpatient 2 ER	//Outpetient 3 □ DOA	26. I	PLACE OF DEATN (Ch	PERFOI 1 YES :	RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	HOSPITAL:	//Outpetient 3 □ DOA	26. I OTHER: 4 Nursing No ME OF 28c. IN VURY	PLACE OF DEATN (Ch	PERFOLITION OF SECRETARY OF SEC	RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
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25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER MANAGE 30. NAME AND ADDRESS OF PERSON WHO	HOSPITAL: 1 Inpatient 2 ER 28e. OATE OF INJ (Month, Dey.) 28e. PLACE OF IN building, etc.	URY 28b. Till Surry 28b. Till Surry At home, ferm (Specify) knowledge, death occulination end/or investigation	26. I OTHER: 4 Nursing No ME OF NJURY M 1 , street, factory, off	PLACE OF DEATN (Ch me 5 Residence IJURY AT ORK? YES 2 NO lice ts end plece, end dus death occured at the	PERFOL 1 VES : 2 Other (Specify) 28d. DESCRIBE NOW 28i. LOCATION (Street City or Town, State to the ceuse(s) and me time, date end place, e	end Number or A	AAALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Rural Route Number, December 2 Stated. GNED (Month, Day, Year)			

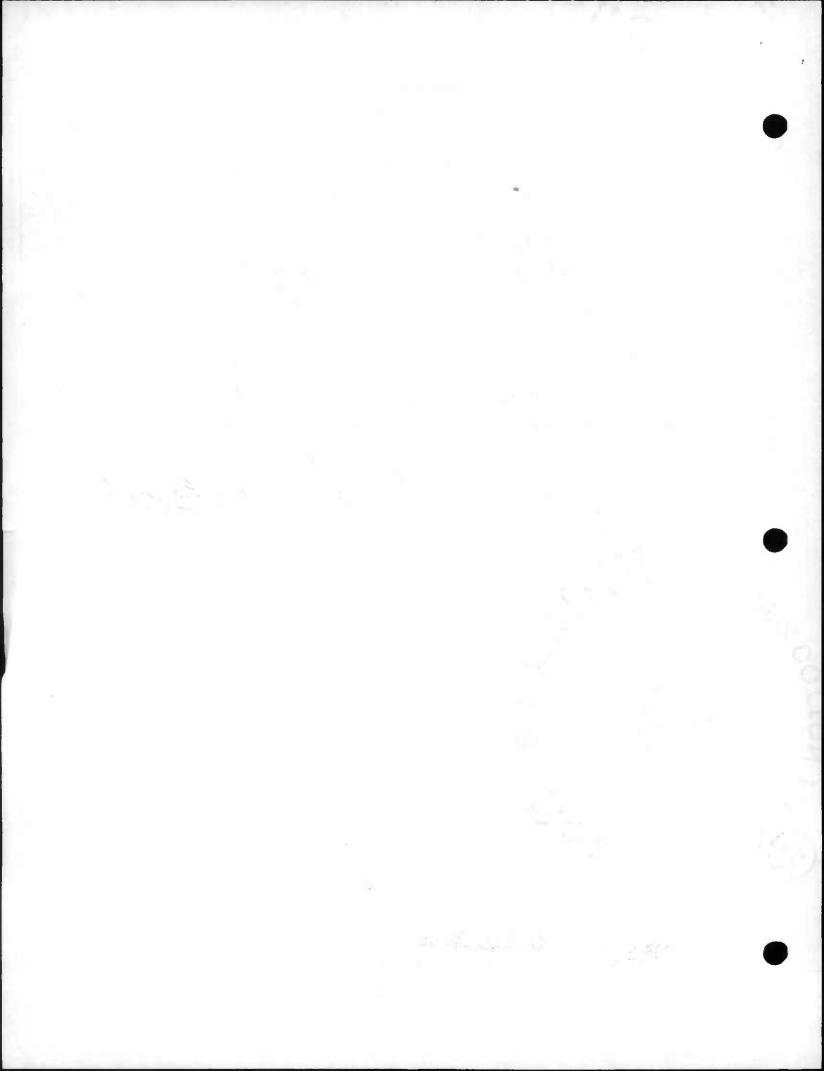
permit. Pages 1, 2, 3 should

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31. DATE FILED (Month, Day, Year) MAR 3.1 1993

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician
to the Contract, practical that this certificate his over sympt by the attending physicial and comperey into his provided in the build-frame of the part of the pa
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

93 08600 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 546 ALICE 30 3 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (SI 212-03-618 1 - M 2 DF 2-02-9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH HAR. DIRECTOR ENERAL HOSPITAL STON ALLSTON RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BARTO TOWSON 1 YES 2 NO FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2120 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-11. MARITAL STATUS WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE — Americal Indian Black White, etc. If yes, specify Cubar 1 Never Merried 2 Married IF YES, GIVE WAR OR DATES Specify: BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY lary (0-12) College (1-4 or 5+) TELE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 04150 NNIE SMITH BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Mu 2 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (No 20c. LOCATION - City or To Burlel 2 Cremation 3 Re □ Donation 5 □ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY C VANS Enter the dige ses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate beart failure. List of interval Bety Onset and Death IMMEDIATE CAUSE (Final disease or condition DUE TO (OR AS A COMSEQUENCE OF) mona resulting in death) MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY 1 TES 2 NO OF DEATH? 1 | YES 2 | NO BY PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL: SER/Outpetlent 3 DOA 1 VES 2 NO OTHER: e 5 - Residence 8 - Other (Specify) 4 - Nu 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 2 Accident 5 Pending investigation 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) BE COMPLETED 6 Could not be 4 Homicide CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or in occured at the time, date and place, and due 296. SIGNATURE AND THE DE 29c. LICENSE NUMBER 29d. DATE SIGNED (Me 3 58 30 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (17EM 27) (Type, Print) 21015 FNEILIC (INDA



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he law requires that the death certificate be executed within 24 hou	has been sinced by the attending physician and nomineate filled
W: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or arm more	Special from strength has added from the strength of some property of the few the decoders name I when don't has decomined for now as the to

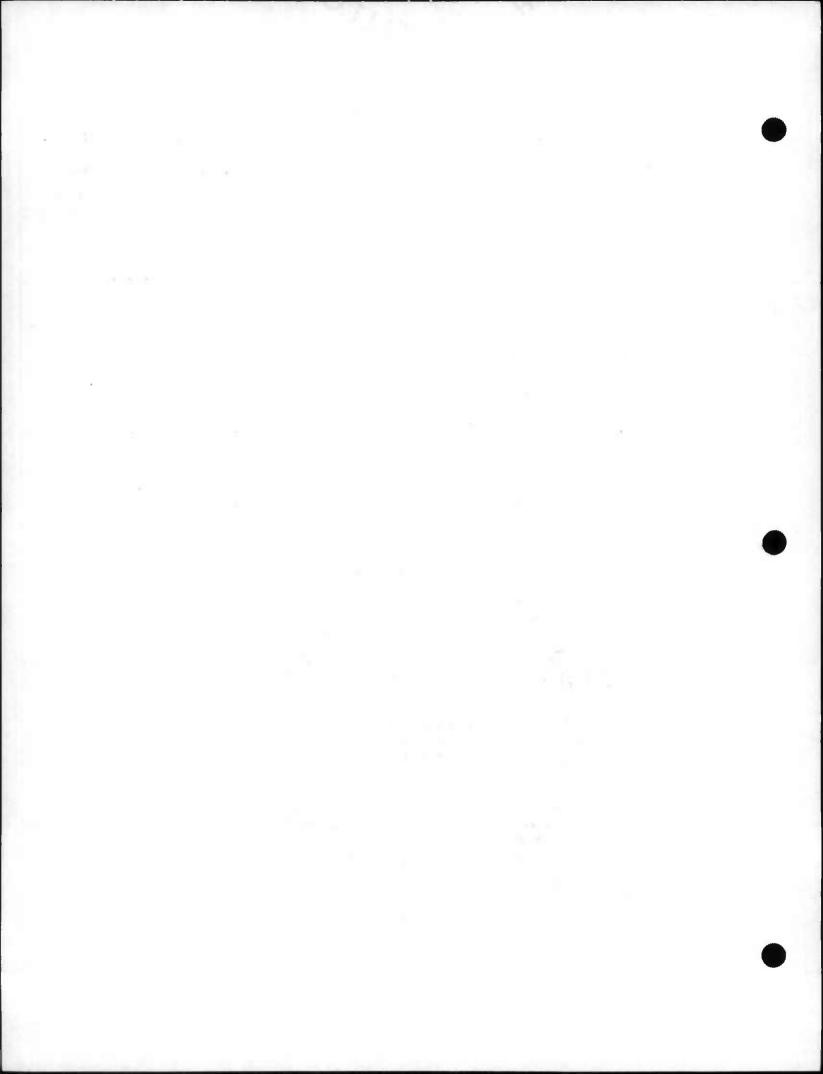
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-14

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be fied within 72 hours after death with the State Dept. IMPORTANT: If Hem 28 is marked, or Hem 23

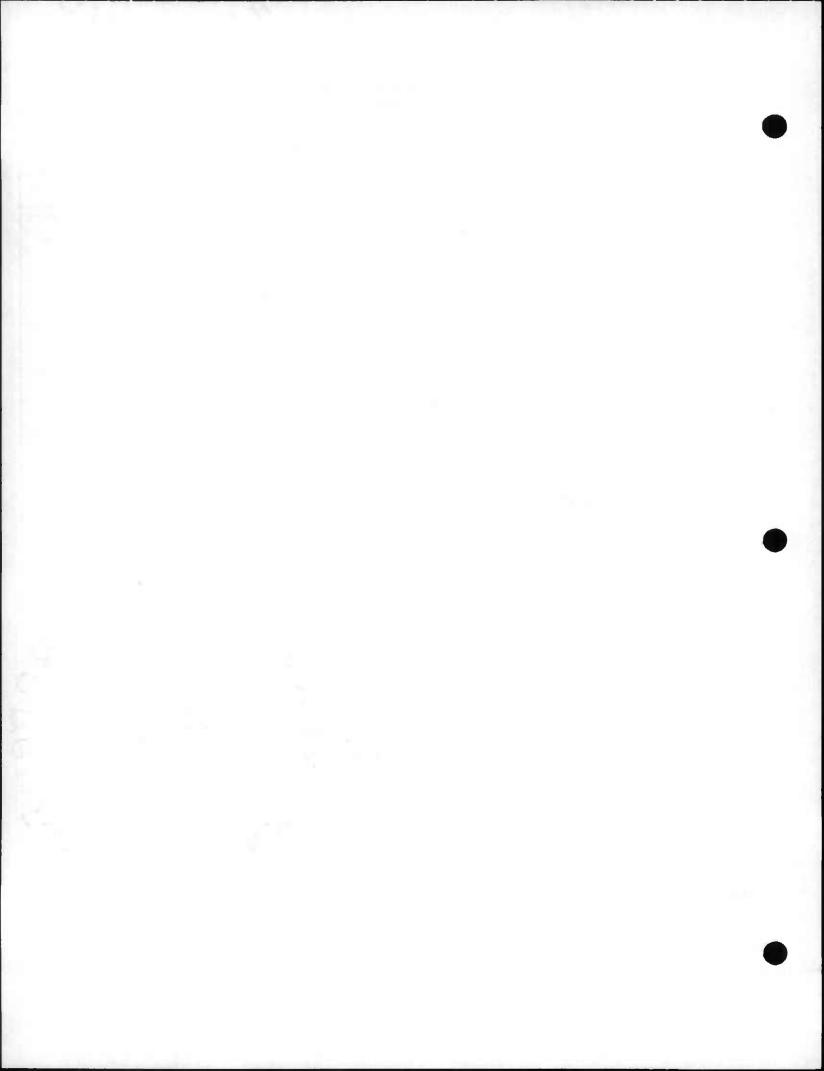
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	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		MENT OF H		MENTAL HYGIENI REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Lawrence K.	Buschmann				March 27	, 1993	9:55 A. M
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In yrs		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	6. BIRT	HPLACE (State or Foreign
	216-01-0219 9e. FACILITY NAME (If not institution, give street	₹ M ² □ F 78	YRS.	ONTHS DAYS	HOURS MIN.	Aug. 7,19		Jersey
E I	Fallston General			Falls	R LOCATION OF DE	ATH	9c. COUNTY OF	
1	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCAT			HGI I	10d. INSIDE CITY
DIRECTOR		ford		Forest I				LIMITS?
₹	10e. STREET AND NUMBER			101.	ZIP COOE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	509 Forest Valle				21050		U.S.A	
5	11. MARITAL STATUS 12 1 Never Married 2 Married	2. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2	NO	If yes, spe	city Cuban, Mexica	IC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	Blac	E — Americen Indian, ck, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 - YES	2 NO Specify		Spec	White
TEC	15. DECEDENT'S EDUCATI (Specify only highest grade corr	ION 16a.		SUAL OCCUPATION OF MORE		16b. KIND OF BUS	INESS/INDUSTRY	
COMPLETED	Elementary/Secondary (6-12) C	College (1-4 or 5+) N/A Ce		,	Tochnic	cian De	ntol Io	h
NO.	17. FATHER'S NAME (First, Middle, Last)	11/11 00	. T CITTE	Delica		ME (First, Middle, Maiden S		D
BEC		chmann			Mary	Fox	ζ	
2	19a. INFORMANT'S NAME (Type/Print)	(loute Number, City or Town		
	Naomi M. Buschmann	20b. PLA		orest Va		DATE 20c LOC		
	1 N Buriel 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State cemetery MO1	eland	Memoria]	Park	3/30 Bal		
	21. SIGNATURE OF FUNERAL SERVICE LICENS	1. A. A			nek Fune			
	LAKEN B	HIRCH /L		9705 I	Belair Ro	ad, Baltin	nore, MD	21236
	23. PART I. Enter the disease, or com shock, or heart failure. List	iplications that caused the tonly one cayse on each	deeth. Do no line.	t enter the mo	de of dying, sucl	ss cardiec or respir	ratory errest,	Approximate interval Between
	IMMEDIATE CAUSE (Finel disease or condition	Keah	1	ilw	0			Onset and Death
	resulting in death) e	DUE TO (OR AS A CON	ISEOURIE POF	1110	1	101.0	C = D:	
N	Sequentially list conditions,		XX	vere	UMA	slege	000	
CERTIFICATION	if sny, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CON	ISEOUENCE OF):		Com	(/		
FI	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CON	SEQUENCE OF)					
Ë	resulting in death) LAST							
AL	PART II. Other significant conditions of	ontributing & death but n	ot resulting in	the underlying	ceuse given in	Part i. 24a. WAS AN /		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DIC	MAH	, me	eet	a		1 TYES 2		COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC		100				_		1 TES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL			26 PL	ACE OF DEATH (Che	ock only one)		
SICI	EXAMINER?	OSPITAL:		OTHER:	The section	6 Other (Specify)		
	27. MANNER OF DEATH	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c, INJ	JRY AT	28d. DE\$CRIBE HOW IN	JURY OCCURED	
ВУ	1 Natural 5 Pending 2 Accident Investigation				ES 2 NO			
	3 Suicide 6 Could not be detarmined	28e. PLACE OF INJURY — A building, etc. (Specify)	t home, farm, str	reet, factory, office		281. LOCATION (Street at City or Town, State)	nd Number or Rural	Route Number,
LEI	29a. CERTIFIER CERTIFYING PHYSICIAL	N: To the best of my knowledge	death occurred	at the time date	and place, and due	to the several and man		
COMPLETED	one)	On the basis of examination end						(e) and menner ee stated.
BE C	296. SIGNATURE AND STILL OF CENTIFIER				29c. LICENSE NUN	BER . L. F. F. F.	29d. DATE SIGNE	D (Month, Day, Year)
10	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH	(ITE 27) /= (Print)— A A	016	444	1 42	27/43
	V.S.NA	HR M.	D -	Porll	Stan	-140	2100	<i>4</i> 7.
	MAR 3 1 1993	32. REGISTRAR'S SIGNATUR						
	mail 3 1 1993	Julia Davidson	Handelle					



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	N. Carlo	1. DECEDENT'S NAME (First, Middle, Last) KATHERINE	F. CUNNI	NGHAM	2. DATE OF DEATH DAY MONTH DAY 1		А.м			
should		4. SOCIAL SECURITY NUMBER 219-03-3467 9a. FACILITY NAME (If not institution, give street and number)	YRS. MONT	THE DAYS HOURS MIN.	March 2.189		reign			
1, 2, 3	стов	Trinity Geriatric Center Woodlawn Baltin								
permit. Pages	DIRE	Maryland Baltimore		wn or Location		10d. INSIDE CITY LIMITS? 1 \square YES 2				
sictan. Al-transit per	FUNERAL	7600 Clays Lane 11. MARITAL STATUS 12. WAS DECEDENT EVER IN		10f. ZIP CODE 21207 13. WAS DECEMBENT OF HISPANIC		U.S.A. No. 14. RACE — American India	en.			
	₽	1 Never Married 2 Married FORCES? 1 YES IF YES, GIVE WAR OR DA	ATES	If yes, specify Cuben, Mexican, 1 YES 2 NO Specify:	Puerto Rican, etc.)	Specify: White, etc. White				
ND 212 hospital or a ached for we	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yn¹ S College (1-4 or 5 +)	16a. DECEDENT'S USUA (Give kind of work d life. Do NOT use retir Homemak	lone during most of working ed.)	16b. KIND OF BUSINE	SS/INDUSTRY				
at on	BE CON		cher	10. MOTHER'S NAME	E (First, Middle, Maiden Surr UNKNOWN					
retain 5 sho	5	Mrs. Margaret P. Hand		Harcourt Rd.						
ALIIMOKE, death, Page 6 may be funeral director, page I. examiner must be		1 X Burial 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify)	place and oate of bis netery, crematory or other place. Meadowri	dge 3/31/93	B	Sev. MD				
EAL IN ter death, Pag the funeral di wal.		Faul L Hartwell 12	di csock,oi .	Leonard J. Ruc	k, Inc. 53	re,MD 21214 05 Harford Rd.				
24 hours af filled in by ion, or remo		23. PART I. Enter the diseases, or complications that caused shock, or heart feiture. List only one cause on ear IMMEDIATE CAUSE (Final disease or condition resulting in death)				Onset and	etween			
be executed cian and corrior to burial, raumatic ex	CATION	disease or condition resulting in death) a. Cardio - Dulmman are consequence of: Due to (or as a consequence of): Ca of Bladder with Metal tests Due to (or as a consequence of): Due to (or as a consequence of): Ca of Bladder with Metal tests Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
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TAL RECORDS, F.O. The law requires that the death certifule lass been signed by the attending are Dept. of Health and Mental Hygie em 23 shows any injury, or other controls.	SICIAN: MEDICAL CERTIFI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	CONSEQUENCE OF):	26. PLACE OF DEATH (Check	PERFORMEI 1 VES V	O? AMAILABLE PRIOR COMPLETION OF C	TO			
PHYSICIAN: The law requires that the death certificate has been signed by the attending with the State Dept. of Health and Mental Hygierked, or Item 23 shows any injury, or other	MEDICAL CERTIFI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death be examined. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 NO 1 Inputent 2 ER/Output 1 Inputent 2 ER/Output 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	consequence of): ut not resulting in the uetient 3 □ DOA □ 28b. TIME OF INJURY	26. PLACE OF DEATH (Check HEBA) MURING Home 5 Residence 8 28c. INJURY AT WORK? 1 YES 2 NO	PERFORMED 1 YES Conly one) Other (Specify) 28d. DESCRIBE HOW INJUI	MAILABLE PRIOR COMPLETION OF COF DEATH? 1 YES 2 I	TO			
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DIRECTOR OF VITAL RECORDS, F.O. DIRECTOR DS, F.O. OPPECTOR. After this certificate has been signed by the attending hours after death with the State Dept. of Health and Mental Hypie Heart 28 is marked, or item 23 shows any injury, or other properties of the proper	BE-COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death be described by the conditions contributing to death be described by the conditions contributing to death be death by the conditions contributing to death be death by the conditions contributing to death by the condition	ut not resulting in the	26. PLACE OF DEATH (Check HED. Nursing Home 5 Residence 8 28c. INJURY AT WORK? 1 YES 2 NO factory, office 2 the time, data and place, and due to my opinion, death occured at the lime.	PERFORMED 1 YES Conly one) Other (Specify) 18d. DESCRIBE HOW INJUITED City or Town, State) the cause(a) and manner the, date and place, and di	MAILABLE PRIOR COMPLETION OF COMPLETION OF COF DEATH? 1 YES 2 I	TO CAUSE			
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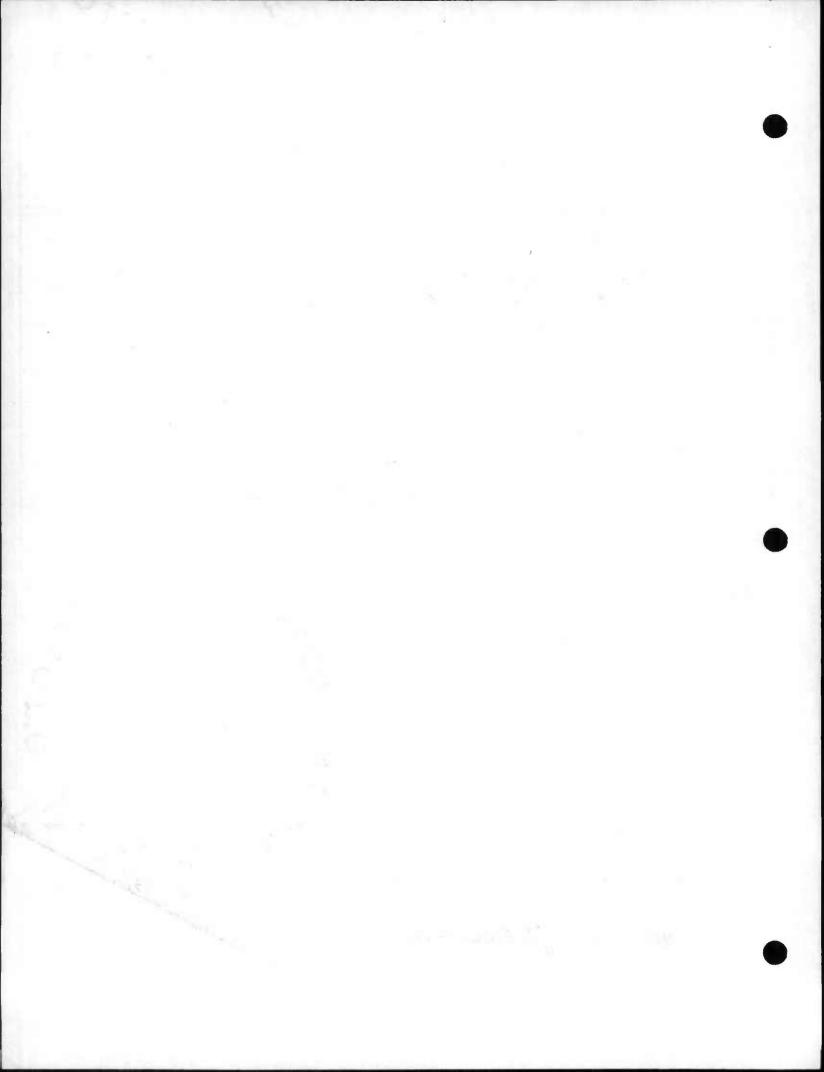
93 08603

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

		1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH A CERTIFICATE OF DEAT		SIENE . NO.						
		1. DECEDENT'S NAME (First, Middle, Last) EASTER CHRISTIAN	2. DATE OF DEA MONTH		3. TIME OF DEATH					
_		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR IF UNDER 2 F S YRS. MONTHS DAYS HOURS		н. а	BIRTHPLACE (State or Foreign Country)					
2, 3 should	OR	9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL BALTIMORE C		9c. COUNTY BALTI						
Pages 1, 2	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION			10d. INSIDE CITY LIMITS?					
ermit. P	AL DI	100. STREET AND NUMBER 101. ZIP CODE		10g. CITIZEI	1 YES 2 ND					
transit p	FUNER.	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF	HISPANIC ORIGIN? (Speci	4.5	5.4					
the burial-transit permit.	BY FL	IS. WIS DECEMBERT OF	Mexican, Puerto Rican, et		. RACE — American Indian, Black, White, etc. Specify: Black					
ed for use as	PLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ### DO NOT use retired.)	18b. KIND 0	DF BUSINESS/INDUS	TRY					
be detached at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	ER'S NAME (First, Middle, M	ialden Surname)						
should	TO BE	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number of		or Town, State, Zip Co	ide)					
page		20a, METHOD OF DISPOSITION 20b, PLACE AND DATE OF DISPOSITION (Name of		De. LOCATION — City						
funeral director, p xaminer must		Surfal 2 Cremation 3 Ramoval from State Cametery, prematory or other piece Specify State Cametery, prematory or other piece Specify State Cametery, prematory or other piece Specify State Cametery, prematory or other piece Specify State Cametery, prematory or other piece Specify S		PATINSYI	LLE & M. J.					
9 7		304) Bulralo								
completely filled in by the ial, cremation, or removal.		23. PART I. Entar tha diseases, or complications that caused the death. Do not entar the mode of dying shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Die TO (OR AS A CONSEQUENCE OF):	g, such as cardlec or	respiratory arrest	t, Approximate interval Between Onset and Death 2 days					
ending physician and con I Hygiene prior to burial, or other traumatic ev	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. MVOCAVAIN INTROVCTION DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d								
certificate has been signed by the attract the State Dept. of Health and Mental, or Item 23 shows any Injury,	MEDICAL	COYONARY AVIETY DY FASS GRACH 11/62	PE	AS AN AUTOPSY ERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
icate has State Depr Item 23	SICIAN:	EXAMPLE? HOSPITAL: OTHER	ATH (Check only one)							
with	РНУ	1 YES 2 NO 1 Inpettent 2 PER/Outpettent 3 DOA 4 Nursing Home 5 Res 27. MANNER OP DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 Total S Pending Investigation Investigation	28d. DESCRIBE	HOW INJURY OCCUR	HED					
cTOR: Afte s after deat 28 Is m	тер ву	2 Accident investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	261. LOCATION (S City or Town,	Street and Number or (State)	Rural Route Number,					
THE FUNERAL DIRECTOR: After if fled within 72 hours after death PORTANT: If item 28 Is mar	COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred.								
TO THE FUNERA De filed within 7 IMPORTANT: 1	TO BE	Joseph M. Umes no	ISE NUMBER	29d. DATE S	IGNED (Month, Day, Year)					
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)								
		31. MAR 3 1 993 Julia Distriction of the second of the sec								



B. BIRTHPLACE (St

10g, CITIZEN OF WHAT COUNTRY?

Specify

USA

9c. COUNTY OF DEATH

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 YES 2 NO

White

Approximata

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

15/93

31

interval Between

Onset and Death

: 30 PM

REG. NO

DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH 00 r150 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. ids IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 1 M 2 X F Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give stre 9b. CITY. TOWN OR LOCATION OF DEATH Harford MA DIRECTOR 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Cecil County Elkton permit. 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE burial-transit 102 B Elkwood Road 21921 hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the bunal-tran 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— H was specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cuban, Mexican, Pr 1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION becily only highest grade complete 166 KIND OF BUSINESS/INDUSTRY /Spe Elementary/Secondary (0-12) College (1-4 or 5+) Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Timothy Copeland Christine Miller BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number City or Town, State, Zin Code) 2 Christine Miller 102 B Elkwood Raod, Elkton, MD 21921 pe 20a. METHOD OF DISPOSITION
1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION /Name of 20c. LOCATION - City or Town, State must OC Donation 5 Other (Specify) 21. SIGNATURE OF FUNDAM, SERVICE LICES event, the medical examiner Ronald State Anatomy Wade, Dir 22. NAME AND ADDRESS OF FACILITY 3/25/93 655W.Baltimore St, Balto, MD 21201 this certificate has been signed by the attending physician and completely filled in by the with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. 1. Wweels gestyte MMEDIATE CAUSE (Final Extreme prengtisity / 145 vhicent long ollochopment disease or condition resulting in death) HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760, OUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING CAUSE (Disease or injury Injury, or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a, WAS AN AUTOPSY PERFORMEO? item 23 shows any 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER 1 - Inpatient 2 - ER/Outpetient 3 - DOA me 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCURED is marked, 1 Natural 5 Pending Investigation 1 YES 2 NO BY After I 2 Accident 28e. PLACE OF INJURY - At home, term, street, fectory, office 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED FUNERAL DIRECTOR: within 72 hours after 28 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT be filed within 72 hours at IMPORTANT: If Item 2 29e. CERTIFIER
(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date end place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner se stated. 29b. SIGNATURE AND JITLE OF CERTIFIER 29c. LICENSE NUMBER BE VSMiBul und 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

REGISTRAR'S SIGNATURE

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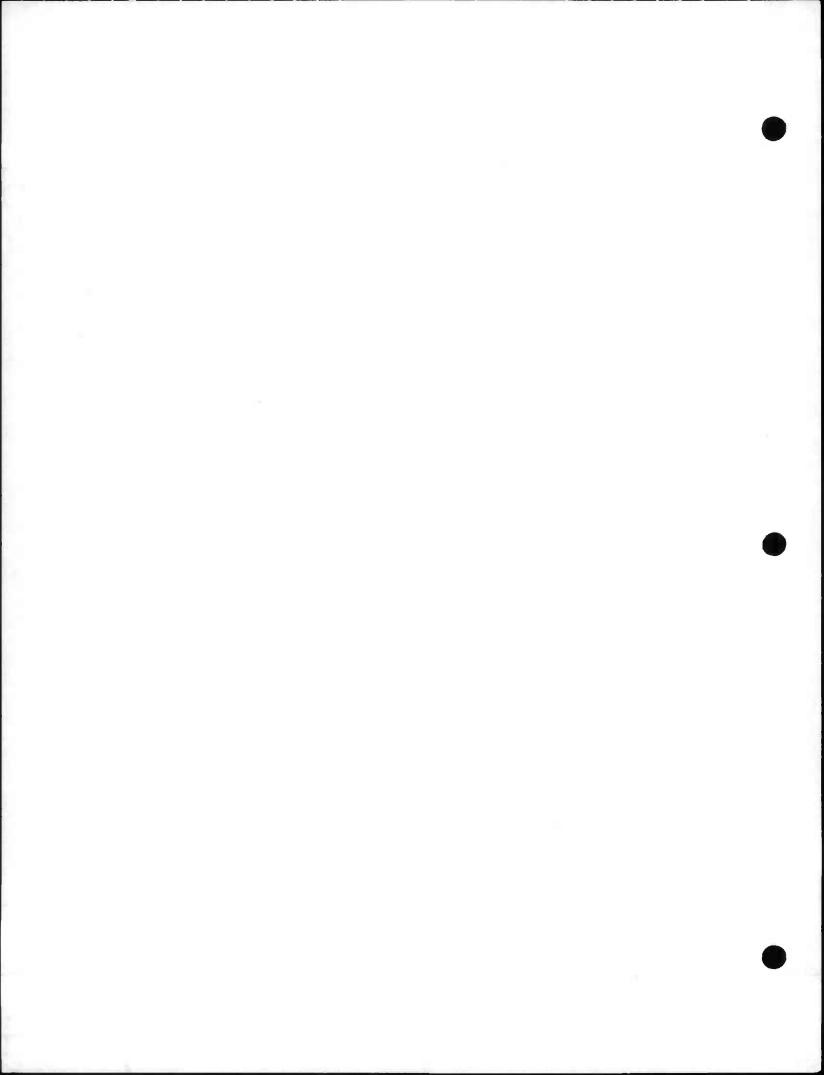
31. DATE FILED (MONTH, Day, Year)
WAR 31 1993

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

FOR STATE REGISTRAR

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely, be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremat	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event,
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH 6:00 Pm 23 Charles William Compher
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) March 1993 7. DATE OF BIRTH

(Month, Day, Year)

Oct. 1, 1912 IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign Virginia 1 XXM 2 🗌 F DAYS HOURS 223-16-1008 80 YRS. 9a. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Frederick none Frederick RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Frederick Frederick 1 YES 2 NO 10e. STREET AND NUMBER **FUNERAL** 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4133A Ballenger Creek Road 21701 U.S. 06 A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11, MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married
3 Divorced Specify: BY Caucasian COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Security Guard Aluminum Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles Elbert Compher Buda Harrison BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 4133A Ballenger Creek Road, Virginia Swope Compher Frederick, Md. 21701 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION — City or Town, State Union Cemetery Lovettsville, Va. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Brown Funeral Home P.O. Box 320 Lovettsville. Virginia 22080 23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errect, Approximate shock, or heert fellure. List only one cause on each line. interval Batween IMMEDIATE CAUSE (Final Onset and Death disease or condition 6 mor resulting in death) OUF TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 4 Nursing Home 5 Residence 8 Other (Specify) 1 TYES 2V 1 | Inpatient 2 | ER/Outpetient 3 | DOA 27. MANNER OF DEATH 20a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 4 Homicide determined 29a, CERTIFIER 1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) MEGICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFICATION OF CERTIFICATIO 29c. LICENSE NUMBER BE

0166

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MY MER. MY MER. 32 REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year)

1993

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3/24/93

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, JAN. The law requires that the death certificate be executed TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: A be filed within 72 hours after of IMPORTANT: If item 28 is

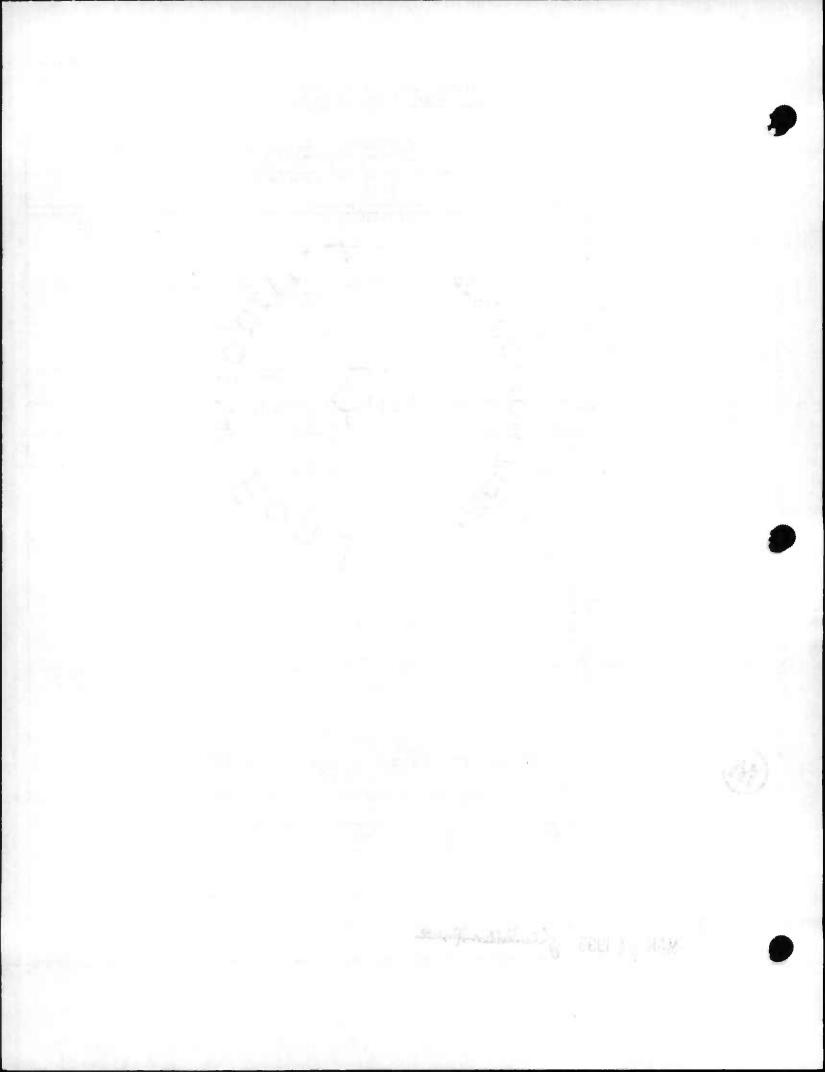
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atending physician. se as the burial-transit permit	
an equives that the destriction that when 24 hours are head. Tage of his per areaned by the despitat of areanong physician. The has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 shows any limitand Mental hygher prior to burlat, cremation, or removal. Then 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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FOR STATE REGISTRAR

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

4. SOCIAL SECURITY NUMB 215-12-0185 9a. FACILITY NAME (II not in:	ER		MAN AGE (In yrs. les					2	2 X	92	959 4
215-12-0185			L AGE (10 VIS. IBS			1			20		/ / м
213-12-0183		1 1 M 2 □ F	- 1		UNDER 1 YEA		R 24 HRS. MIN.	7. DATE OF BIRTS (Month, Day, Ye	ar)	Country)	LACE (State or Foreign
		44	72	- 10 -				FEB. 22,	_		TIMORE
VETERANS	ADMINIS		HOSPIT			IMORE		EATH	9c. COL	JNTY OF DEA	ITN
10a. STATE	10b. COUNTY			Inc CITY T	OWN OR LO	CATION					Od. INSIDE CITY
MARYLAND	BALTIN	IORE				1	(MID)	DLE RIVE	R)		LIMITS? YES 21 NO
	ORN ROA	AD.			WF 1			,			AT COUNTRY?
		2. WAS DECEDENT FORCES? 1 X IF YES, GIVE WAR WW II	EVER IN U.S. AR YES 2 N OR DATES	MED IO	If yes,	specify_Cubi	an, Mexica	n, Puerto Rican, etc	ly Yes or No—	Black, 1	- American Indien, White, etc.
15. DECE (Specify only	EDENT'S EDUCA	TION moleted)	16a. DE	CEDENT'S US	JAL OCCUP	ATION	Ina	166, KIND O	F BUSINESS/IN	DUSTRY	
			IIIe.	Do NOT use re	tired.)		'ny	TRA	NSPORT	ATION	
19a. INFORMANT'S NAME (Ty	rpe/Print)		190	. MAILING AD	DRESS (Stre	et end Numbe	r or Rural F	Route Number, City o	r Town, State, Zi	p Code)	
				2165 G	RAYTH	ORN R	OAD-	BALTIMOR	E, MD.	21220)
		al from State	20b. PLACE A	ND DATE OF D	ISPOSITION	(Name of		DATE 20			, State
		nee 4	MET	ROY CRE	-				BALTI	MORE	
NOT.		1/	24	5	HUB	BARD	FUNE!	RAL HOME	, INC.		
(181	eso.	- 9	9/14	1	410	7 WIL	KENS	AVENUE-	BALTIM	ORE, N	D. 21229
IMMEDIATE CAUSE (Findisease or condition resulting in death) Sequentially list condition from the cause. Enter UNDERLY!! CAUSE (Disease or injust that initiated events	one, liste NG c.	PNE DUE TO (O	UMU, R AS A CONSEC E TUST R AS A CONSEC	MAC DUENCE OF): ATC DUENCE OF):	Pi	osta	k	Conce	<u></u>		Interval Between Onset and Death 7 days
PART II. Other algnificar	d.	Contributing to de	eeth but not re	esulting in t	he underly	ing ceuse	given in	PE	RFORMED?	- 0	TERE AUTOPSY FINDINGS MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
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					26.	PLACE OF D	EATH (Che	ck only one)			
1 YES 2 NO	1;	OSPITAL:	R/Outpatlant 3			ome 5 🗆 Re	esidence	6 Other (Specify	1		
						WORK?	NO.	28d. DEŞCRIBE N	OW INJURY OC	CURED	
3 Suicide 8 0	Could not be	28e. PLACE OF I	NJURY — At her	ne, farm, stree						r or Rural Rou	te Number,
M. CERTIFIED											
(Check only 1 CERTI											nd menner as stated.
296. SIGNATURE AND TITLE	OF CERTIFIER	Boton	n			29c. LtC	ENSE NUM	IBER	29d, DAT	E SIEMED IN	Day, Year)
				-						1	
30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUSE	OF DEATH (ITEN	-	hm	51	1/	A 1H	sail	1	
	10a. STATE MARYLAND 10a. STREET AND NUMBER 2 1 6 5 GRAYTH 11. MARITAL STATUS 1 1 Never Married 2	MARYLAND BALTIM 10e. STREET AND NUMBER 2 1 6 5 GRAYTHORN ROA 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDUCAL (Specify only highest grade oc Elementary/Secondary (0-12) UNKNOWN 17. FATHER'S NAME (First, Middle, Last) WILLIAM J. COLEMAN 19e. INFORMANT'S NAME (Type/Print) CHARLES E. COLEMAN 20e. METHOD OF DISPOSITION 1 Burlat 2 Differention 3 Removed 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNETAL SERVICE LICEN 23. PART I. Enter the diseasea, or conshock, or heart failure. Lie immediate cause. Enter UNDERLYING CAUSE (Pinal disease or condition resulting in death) Sequentially list conditiona, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 26. WAS CASE REFERRED TO MEDICAL EXAMINER? 27. MANNER OF DEATH 1 Matural 5 Pending investigation 28. CERTIFIER CHERTIFYING PNYSICIAL CONTROL OF THE CONTROL OF THE CHERTIFY OF THE	10b. COUNTY MARYLAND BALTIMORE	10e. STATE 10e. COUNTY MARYLAND BALTIMORE 10e. STREET AND NUMBER 2165 GRAYTHORN ROAD 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AR FORCES? 12. YES 2 14. YES 2 15. DECEDENT'S EDUCATION 15. DECEDENT'S EDUC	10e. STATE 10e. COUNTY BALTIMORE B. 10e. STATE 10e. COUNTY BALTIMORE B. 10e. STATE 10e. COUNTY BALTIMORE B. 10e. STATE 10e. COUNTY BALTIMORE B. 10e. STATE 10e. COUNTY BALTIMORE B. 11e. MARITAL STATUS 11e. Maritad 12e. Was DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, QIVE WAR OR DATES WW II 15. DECEDENT'S EDUCATION If YES, QIVE WAR OR DATES WW II 15. DECEDENT'S EDUCATION If YES, QIVE WAR OR DATES WW II 16e. DECEDENT'S USING (Cive with and of work with the December of TRUCK D 17. FATHER'S NAME (First, Mickie, Last) Idea DECEDENT'S USING (Cive with and of work with the December of TRUCK D 17. FATHER'S NAME (First, Mickie, Last) Idea DECEDENT'S USING (Cive with and of the Date of TRUCK D 18. DECEDENT'S USING (Cive with and of the December of TRUCK D 19. MARLING AD 2165 G 20e. METHOD OF DEPTHON SERVICE LICENSES 20e. DEPTHON SERVICE LICENSE	106. CITY, TOWN OR LO	SATTEE SOL COUNTY BALTIMORE SALTIMORE SATTEMENT SOLUTION BALTIMORE SALTIMORE SALTIMO	1906. STRIET AND NUMBER 1906. COUNTY 1906. STRIET AND NUMBER 2165 GRAYTHORN ROAD 1907. STRIET AND NUMBER 2165 GRAYTHORN ROAD 1907. STRIET AND NUMBER 2165 GRAYTHORN ROAD 120 Married 2	100. STATE 100. COUNTY 100. COUNTY 100. COUNTY 100. STATE 90. COUNTY MARYLAND BALTIMORE 90. STREET AND NUMBER 21.65 GRAYTHORN ROAD 90. STREET AND NUMBER 21.65 GRAYTHORN ROAD 11. MARTIAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 12. MARTIAL STATUS 13. Never learned 2 started 13. Wildowed 4 Divorced 15. Never learned 2 started 15. Never learned 2 started 15. Never learned 2 started 16. Never learned 2 started 17. FOR COST 1 (M) YES 2 JMO 17. WILLIAM J. OCLEMAN 16. DECEDENT'S EDUALORY 17. FATHER'S NAME (First, Middle, Land) 17. FATHER'S NAME (First, Middle, Land) 17. FATHER'S NAME (First, Middle, Land) 18. MOTHER'S NAME (First, Middle, Land) 18. MOTHER'S NAME (First, Middle, Land) 19. MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. SANTTH 18. DECEDENT'S USUAL COUNTY IN MARCART M. MARCART M. MARCART M. SANTTH 18. DECEDENT SANTTH 18. DECEDENT SANTTH 18. DECEDENT SANTTH 18. DECEDENT SANTTH 18. DECEDENT SANTTH 18. DECEDENT SANTTH 18. DECEDENT SANTTH 18. DECEDENT SANTTH 18. DECEDENT SANTTH 18. DECEDENT SANTTH 18. DECEDENT SANTTH 18. DECEDENT SANTTH 18. DECEDENT SANTTH	THE MARYLAND BALTIMORE 106. STREET AND NUMBER 216.5 GRAYTHORN ROAD 107. PGOCE 212.20 108. COUNTY 109. CO	



3. TIME OF DEATH

BIRTHPLACE (State or Foreign Country)

11:10P M

4. SOCIAL SECURITY NUMBER

ISABELLE B.

213-10-9589

76

8. AGE (In yrs, last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

CHENOWETH

5. SEX

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27

YEAR

93

2. DATE OF DEATH DAY

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7. DATE OF BIRTH (Month, Day, Year)

	1 1	213-10-	9589	1 M 2 X F	/	O YRS.					7 7	/19/	101d	M:	ARYLAND
should	1 1	9e. FACILITY NAME (If not in	stitution, give s	street end number)			9b, CIT	Y, TOWH O	R LOCATI	ON OF DE		1131		Y OF DEAT	
3 8	۳ ا	GREATER	BALT	IMORE M.	EDIC	CAL CE			TOWS		LAI!!			TIMO	
.2	1 8 1	RESIDENCE OF DEC													
	M	10e. STATE	10b. COUNT	Υ		10c. CI	TY, TOWN	OR LOCAT	ION					10	d. INSIDE CITY
permit. Pages	DIRECTOR	MARYLAND	BA	LTIMORE		L	JTHE	RVI	LLE					1.	LIMITS?
Ĕ		10e, STREET AND NUMBER	211					100	ZIP COD	-					YES 2 NO
8. #	MA							101.	ZIF COD						T COUNTRY?
DZO physician. burial-transit	FUNERAL	1324 WAR	WICK							793				U.S.A	1.
DZO physician burial-trac	교	11. MARITAL STATUS 1 Never Merried 2	Marriad	12. WAS OECEDENT FORCES? 1	YES	U.S. ARMED	13.	WAS DEC	ENDENT (OF HISPAN	NC ORIGIN in, Puerto R	(Specify Yes	or No— 1	4. RACE Black, W	American Indien, hite, atc.
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use use	밑	(Specify only	EDENT'S EDU highest grade	completed)		(Give kind of	work done	during mos	IN st of worldi	ng	16b.	KIND OF BUS	INESS/INDU	STRY	
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V LA	COMPLET	12 yrs				Accom	reing				,	opper	ω.		
4 5 M E	8	17, FATHER'S NAME (First, M	iddle, Last)		~				18. MOT	HER'S NA	ME (First, M	iddle, Maiden	Sumeme)		
F 2.4	l w l	Antione			Gr	rigitis			Ma	rie		Har	mon		
retained 5 should notified	8	19a. INFORMANT'S NAME (7)	ype/Print)			19b. MAILIN	G ADDRES	S (Street a	nd Number	or Rural I	Route Numb	er, City or Town	n, State, Zip C	ode)	
	임	Thomas M	. Chen	oweth								ille,			
may be or. page		20a. METHOD OF DISPOSIT			20b.	PLACE AND OATE					OATE	-	CATION - CH		Cinta
Bector.		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other		ioval from State	ceme	st Holy	other place	e omo	1 C		3-3				
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or de		R	-41	Ly								vson,			
nours after d in by the or removal		23. PART I. Enter the di	seasea, or	complications that	caused	tha death. Do	not ente								Approximata
d in or re		anock, or h	aart fallure.	List only Dns caus	e on aa	ch line.			•					,	Intarval Between
		IMMEDIATE CAUSE (Finel disease or condition										Onset and Death			
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be es sian a sor to or to	Ě	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING DEHYDRATION DUE TO (OR AS A CONSEQUENCE OF):													
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n certificate inding physical Hygiene pri		that initieted events resulting in death) LAS		DUE TO (OR AS A	CONSEQUENCE (HF):							1	
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- 2 e = 3	ပ	PART II. Other algolifica	nt condition	as contribution to	death hu	t not regulting	In the II	ada duta a		ularam Im	Bart I			Lawren	
T PO II	MEDICAL			- contributing to	Jeath DU	t not resorting	III LINE U	loarlying	cause	givan in	Part I.	24e. WAS AN PERFOR		AVA	RE AUTOPSY FINDINGS MLABLE PRIOR TO
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requires seen sign of Heal	¥													1[YES 2XX10
> 4 4														1	
The little has ate Dem 2	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL					26. PL	ACE OF O	EATH (Ch	eck only one)			
PHYSICIAN: The law this certificate has with the State Dep rked, or item 23	S	1 TES 2 NO		HOSPITAL:	ER/Outpe	flent 3 DOA	OTHE		5 Re	sidence	8 🗆 Other	(Specify)			
PHYSICIAN: this certifica with the St.	PHY	27. MANNER OF DEATH		26e. DATE OF	NJURY	26b. Til	AE OF	28c. INJU	JRY AT	1		RIBE HOW IN	JURY OCCU	REO	
frer this ceath with			Pending investigation	(Month, De	y, Year)	I IN	JURY M	1 Y	RK? ES 2	NO					
Afte deat	ВУ	a Contract		26s. PLACE OF	INJURY -	At home, ferm,	street, fac				26f. LOCA	TION (Street e	nd Number or	Burni Bouts	Number
DR ATTENDING P. DIRECTOR: After the hours after death view 28 is mark	8		Could not be determined	building, e	nc. (Specif	y)		,			City o	Town, State)		TILLIAN FIOLIS	Transon,
DR A DIRECTORIECTO	MPLETE	290. CERTIFIER									_				
4 7 2 m	P P	(Check only		ICIAN: To the beat of r											
HOSPITAL FUNERAL within 72	CO	2 MEDI	CAL EXAMINE	R: On the besis of ex	mination	end/or investigati	on, in my	opinion, de	ath occur	red at the	ilme, date	end place, end	due to the	cause(s) en	d manner es stated.
TO THE HOSPIT TO THE FUNERA De filed within 7	ш	296. SIGNATURE AND TITLE	OF CERTIFIER	R					29c. LICE	ENSE NUN	ABER		29d. DATE S	GIGNED (Mc	rith, Day, Year)
THE THE PO THE PORT	100	arthon	E	whom	>			- 1					.		
FFA	2	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS	E OF DEA	TH (ITEM 27) (Typ)	, Print)							28/9	1 3
		ANTHONY S	SARAF.	1S M.D.	120	5 YORK	RD	LUI	HER	VIL	LE M	D 210	93		
		31. DATE FILED (Month, Day,	Yber)	_32. REGISTRA	'S SIGNA	TURE		-							
		MAR 2 1 1	-	32. REGISTRAF	2	Dode .									

uld be detached for use as the burial-transit permit. Pages 1, 2, 3 should

DIRECTOR

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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event,

COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1993

31. DATE FILED (Month, Day, Year)

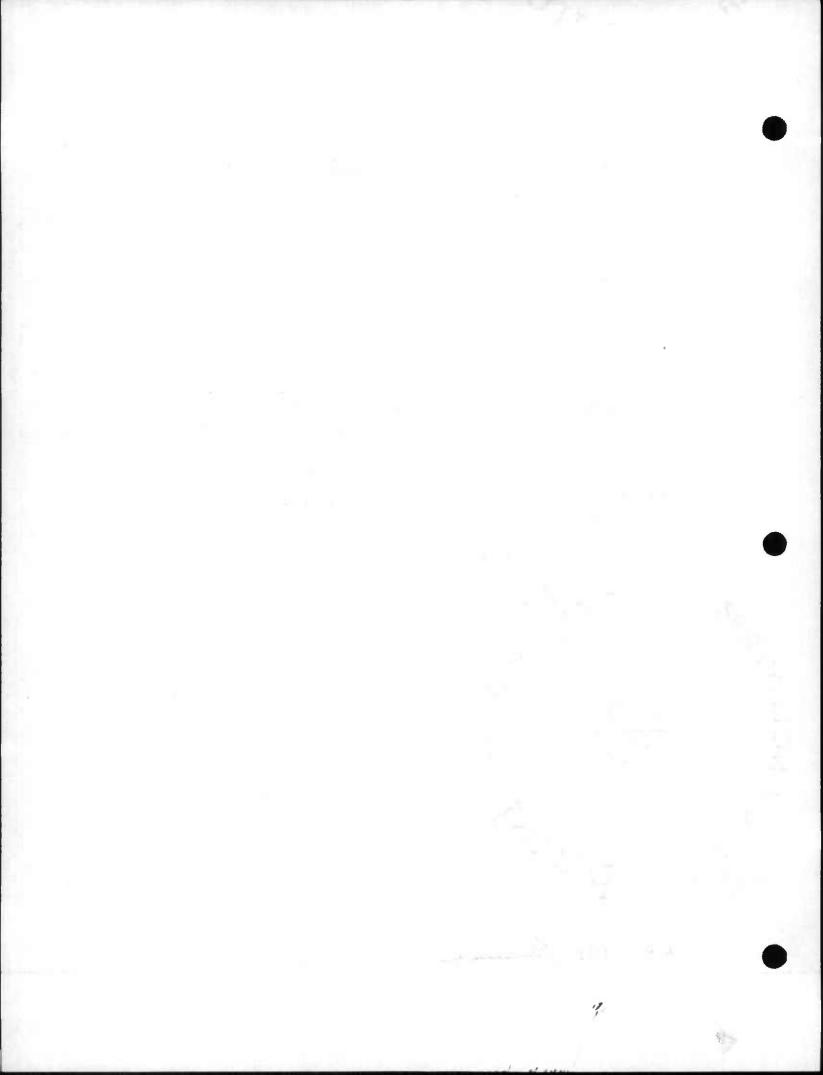
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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retain	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 sho	
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FOR STATE REGISTRAR 93 08608 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Virginia Elizabeth Chamer 900 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 70 1 - M 2XXF 204 16 7148 5/15/22 Pa 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Frederick Memorial Hospital Frederick Frederick 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Carrroll Mt. Airy 1 YES 2X NO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4101 Baltimore Nat. Pike 21771 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Spec#y: White 1 TES 2X XNO Specify 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Sumame) Mary Williams William Yost 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan D. Chamer 2112 Whitehall Rd. Frederick, Md. 20a. METHOD OF DISPOSITION
1. Burial 2 Cremation 3 Ram
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Springfield Cemetery Sykesville, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Haight Funeral Home Sykesville, Md. 21784 P.O.Box 195 23. PART I. Enter the blasses, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death IMMEDIATE CAUSE (Finei disesse or condition_ Sanovara RESPIRATORY DISTRESS resulting in death) DUE TO (OR AS A CONSEQUENCE DF): Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated e resulting in de PART II. Other 25. WAS CASE RI

that initiated events resulting in death) LAST	DUE TO (OR AS A CONSE	QUENCE OF):				
PART II. Other algnificent condition	a contributing to death but not a	resulting in the u	nderlying cause given in P	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 MPNO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 7	28. PLACE OF DEATH (Check only one)					
	HOSPITAL: 1 Diagrament 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Nithural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be detarmined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 YO	28d. DEȘCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify)			I. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
one) 2 MEDICAL EXAMINE	CIAN: To the best of my knowledge, de R: On the basis of examination end/or					
TOTAL DESCRIPTION TO SET SET OF CETTIFIED			29c. LICENSE NUME	29d. DATE	SIGNED (Month, Day, Year) 3 \ 2 4 - \ 0 3	
36. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEATH (ITE	M 275 (Type, Print)				

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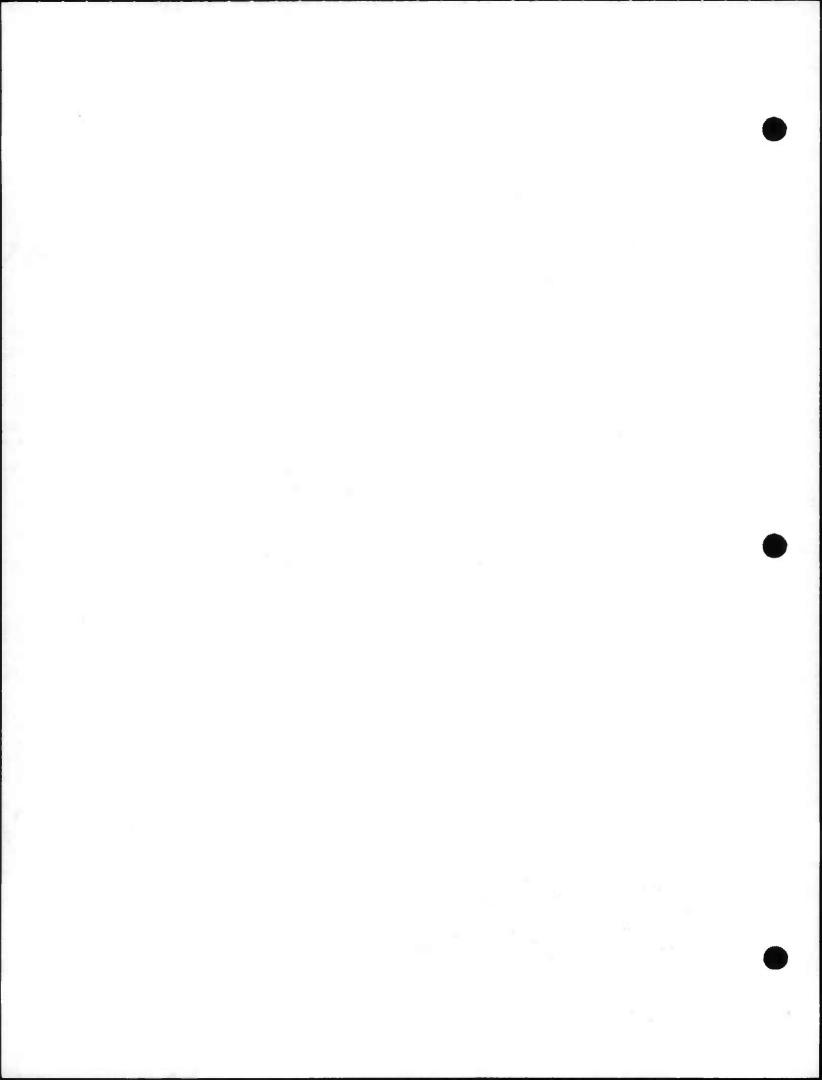
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FINERAL DIRECTOR: After this certificate has been stined by the afteroiding physician and completely filled in by the fineral director name 5 should be described for the burst some some forms.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTA CERTIFIC	ENT OF H	EALTH AND DEATH	MENTAL HYGIEN		
3	1. DECEDENT'S HAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	THOMAS		DRAKE		JR.	03 2	7 199	
1	4. SOCIAL SECURITY HUMBER 217-64-5127		20	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	C	IRTHPLACE (State or Foreign ountry)
	9a. FACILITY HAME (If not institution, give str	1 M 2 - F		-30	- Mai	12-16-1	954	Md
œ	4100 BLOCK PLI		91		IMORE	EATH	9c. COUNTY C	F DEATH
1 6	RESIDENCE OF DECEDENT	MFCO ROAD		DALI	IMORE			
DIRECTOR	10e. STATE 10b. COUNTY			imore	ЮН			10d, INSIDE CITY LIMITS?
	10e. STREET AND HUMBER		1 10011		ZIP CODE			1 X YES 2 NO
RA	2658 Oswego Aver	2110		107	21215			S A
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	EHDENT OF HISPA	HIC ORIGIN? (Specify Ye	s or No — 14. R	IACE — American Indian
BY F	1 N Hever Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 Y YES	2 HO	If yes, sp	2 X HO Specif	in, Puerto Ricen, etc.)		Black, White, etc.
	15. DECEOENT'S EDUC	ATION	44 2505251110					Black
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mo:	IN st of working	16b. KIND OF BU	SINESS/INDUSTR	Y
P	12th	College (14 of 54)						
ő	17. FATHER'S HAME (First, Middle, Last)					ME (First, Middle, Meider		
BE	Thomas Drake, Sr				Flossi	e A. Mist	er	
2	19e. IHFORMANT'S HAME (Type/Print)					Aoute Number, City or Tox		
	Flossie A. Gorde		PLACE AND DATE OF D		Avenue		·	
	1V Buriel 2 Cremation 3 Remo	val from Stata ceme	etery, cremetory or other Garrison	place)		4293 OW	CATION - City o	
	21. SIGNATURE OF PUNETIAL SERVICE LICE		dari ison	22. HAME AN	ADDRESS OF FA	cirity	riigs mi	115, 110
	+ Partis 4	(bron)			r/H we: Wabash			
	23. PART I. Enter the diseases, or co	omplications that caused	the death. Do not	anter the mo	de of dylng, auc	h as cardiac or resp	Iratory arrest,	Approximate
	shock, or heart fallure. L IMMEDIATE CAUSE (Final	ist only one cause on as	ich line.					intarvai Between Onset and Death
.	disease or condition resulting in death)	GULS 409	MOOM	OPE	eurost			
	_	DUE TO (OR AS A	CONSEQUENCE OF):					
NO	Sequentially list conditions,	DUE TO (OR AS A	CONSEQUENCE OF):					
CAT	If any, leading to immediate cause. Enter UNDERLYING							<u> </u>
E	CAUSE (Disease or injury that initiated events	OUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION	resulting in death) LAST							
AL C	PART il. Other significant conditions	contributing to death bu	it not resulting in t	na undariying	cause givan in	Part i. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS
음						PERFO	IMICO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDIC								1 TES 2 NO
Ä	25. WAS CASE REFERRED TO MEDICAL							
PHYSICIAN:	EXAMINER?	HOSPITAL:		HER:	ACE OF OEATH (Ch			
HYS	27. MANNER OF DEATH	1 Inpatient 2 ER/Outpe 28e. DATE OF IHJURY	28b, TIME OF	28c. IN.II		8 XOther (Specify) 28d, DESCRIBE HOW	ON ST	
ВУ Р	1 Hatural 5 Pending 2 Accident Investigation	(Month, Day, Year)	3 7:501	WO	RK?	SUBJECT		
	3 Suicide a Could not be	28e. PLACE OF IHJURY building, etc. (Speci	- At home, term, stree		2121			IMICO ROAD
13	4 Homicide determined		ON STR	EET		BALTIMO		
COMPLETED		IAN: To the best of my knowle				to the cause(e) end me	nner ee stated.	
ON ON		On the beele of examination	and/or investigation, in	my opinion, de	eath occured at the	time, date end place, er	nd due to the caus	se(e) end menner ee stated.
BE	29b. WOHATURE AND TITLE OF CHATIFIER	18/2			29c. LICENSE NUI	MBER	29d. DATE SIGN	NED (Month, Day, Year)
70	mayor me	~111W			O.C.	M.E.	03	/27/1993
	30. NAME AND ADDRESS OF PERSON WHO	20 -		,	L D-3	1.2	M = 1 = 3	- 3 2222
	31. EST PLED (Mogth, Pps Mars)	A 32 FERS BAR'S SIGU	II Penn	Stree	et, Bal	timore,	maryla	nd 21201
	MHU 3 I 1992 A	The property of the	h-me					



DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL WATHINGS PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL INSTANCE And the State Degr. or Health and Mental Hyghene prior to burial, cremation, or removal.

WHOPRIANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF HE	ALTH AND M	ENTAL HYGIEN		
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH		3. TIME OF OEATH
1 8	EDWard DERF	375hire				3 20	93	
						7. DATE OF BIRTH (Month, Day, Year)	6. E	BIRTHPLACE (State or Foreign
	410 00 07 10		35 YRS.	NTHS DAYS F	IOURS MIN.	1 - 17-		ingland
	9e. FACILITY NAME (If not institution, give stree	t and number)	9	. CITY, TOWN OR	LOCATION OF CEA	тн	9c. COUNTY	
5	2103 Pine Vall	ey DR.		TI	moniu	m	Ba	Himore
[[RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c CITY 1	OWN OR LOCATIO				10d. INSIDE CITY
DIRECTOR	Md. Bas	timore		monium				LIMITS?
	10e. STREET AND NUMBER				IP COOE		100 CITIZEN	1 ☐ YES 2 ☑ NO OF WNAT COUNTRY?
EB	2103 PINE VA	LLEY DR.		100	2109	3		5A
FUNERAL		2. WAS DECEOENT EVER IN	U.S. ARMED	13. WAS DECEN	OENT OF HISPANIC	ORIGIN? (Specify Yes	or No.— 14.	RACE — American Indian, Black, White, etc.
BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES			ly Cuban, Mexican, Modern, NO Specify:	Puerto Rican, atc.)		Black, White, etc. Specify:
								White
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	mpleted)	(Give kind of work life. Do NOT use n	done during most of	of working	16b. KIND OF BU	2.5	
P.	Elementary/Secondary (0-12)	College (1-4 or 5+)	SUPERVI	*		Black	+ Dec	ker
No.	17. FATHER'S NAME (First, Middle, Lest)		30.0		6. MOTHER'S NAME	E (First, Middle, Maiden	Surname	
	EDWARD Dert	pyshire			· ·		1.3	lewith
) BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street and		ute Number, City or Tow		
2	Family Record	15						
	20e. METHOO OF DISPOSITION 1 Description Burlan 2 Cremation 3 Remova		PLACE AND DATE OF		of	DATE 20c. LO	CATION — City	or Town, State
	4 Donetion 5 Dother (Specify)	D	etery, crematory or other	ller Mer		3/30/9 TI	meniui	m. Md
	21. SIGNATURE OF FUNERAL SERVICE LICEN				ADDRESS OF FACIL			
	(xantle)	Lover		2375	York R	of Chines	um M	d 21093
	23. PART i. Enter tha diseases, or com ahock, or heart fellure. Lis	plications that caused	the death. Do not	enter the moda	of dying, such	es cerdiac or respi	ratory arrest,	Approximate
ł	IMMEDIATE CAUSE (Finel			,				interval Between Onset and Death
	disease or condition resulting in death) e	<u>C</u> A	LCINOM OF	4 20	NG			1±3 MD.
		DUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION	Sequentielly list conditions, b.	OUE TO (OR AS A	CONSEQUENCE OF):					
Ä	if any, leading to immediate ceuse. Enter UNDERLYING		,					
Ĭ.	CAUSE (Disease or injury that initiated events	OUE TO (OR AS A	CONSEQUENCE OF):					
E	resulting in death) LAST							
	PART ii. Other significant conditions of	ontributing to deeth be	ut not reauiting in t	he underiving c	ause given in Pr	nrt I. 24s. WAS AN	AUTOBEV	24b. WERE AUTOPSY FINDINGS
CAL				andonymy o	addo giron in re	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC						1 YES 2	□ NO	OF DEATH?
- ≥						-		1 TES 2 NO
A I	25. WAS CASE REFERRED TO MEDICAL			26. PLAC	E OF DEATH (Check	only one)		
PHYSICIAN:		OSPITAL:	etient 3 DOA 4	THER: Nursing Home	Residence 6	Other (Specify)		
됩	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJUR	/ AT 2	8d. OEŞCRIBE HOW I	NJURY OCCURE	0
BY	1 Natural 5 Pending 2 Accident Investigation	, , , , , , , , , , , , , , , , , , , ,			2 🗌 NO			
	3 Suicide 6 Could not be 4 Homicide datermined	28e. PLACE OF INJURY building, etc. (Special	— At home, ferm, streety)	t, factory, office	2	81. LOCATION (Street e City or Town, State)	nd Number or Ru	ural Route Number,
<u> </u>								
APL	29e. CERTIFIER (Check only one)	N: To the beat of my knowle	edge, death occurred a	the time, date en	d place, end due to	the ceuse(e) end men	ner ee stated.	
COMPLETED	2 MEDICAL EXAMINER: C	In the beels of examination	end/or investigation, is	my opinion, deat	h occured at the tin	ne, date end place, en	d due to the ceu	use(s) end menner ee stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIED	1516	for I win	25	c. LICENSE NUMBI	ER	29d. DATE SIG	NED (Month, Day, Year)
2	20 NAME AND ADDRESS OF PERSON WING	Wyce	000	, ,	D1950	3	3	2693
	30. NAME AND ADDRESS OF PERSON WHO CO	JMPLETED CAUSE OF DEA			inte 21	0 1		111 21003
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNA			vite of	4 11mo	niom,	Mg 51003
	MAR 3 1 1993 Aud	K 70	J. m					
السسا	1333 900	La maria de la Maria	West-					DUMAN AS Don AND

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

e hos	stache	nce.
E E	be d	at o
10 THE HUSPLIAL OH ALLENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos-	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,
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2	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the firbe within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal,	E
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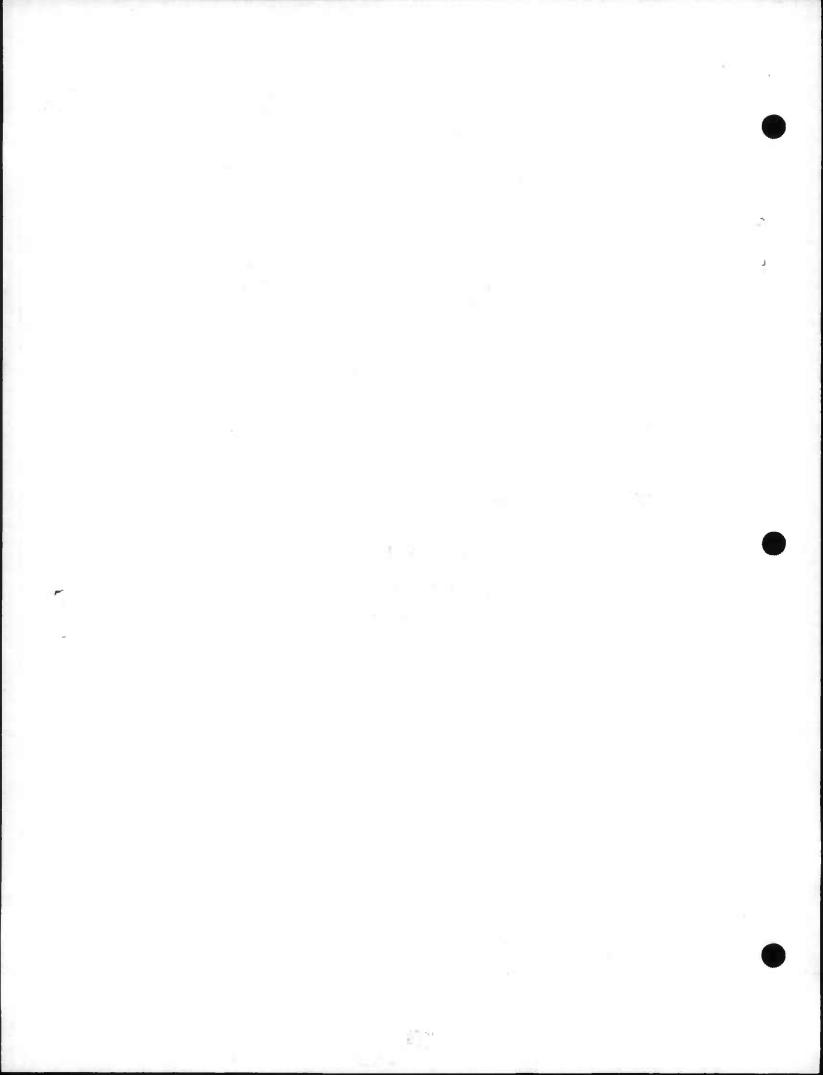
31. DATE FILED (Month

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

38, REGISTRAR'S SIGNAURE

560

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /		NT OF HEALTH AND TE OF DEATH	MENTAL HYGIENE REG. NO.	93 08611
	1. DECEDENT'S NAME (First, Middle, Last) EDNA L	DEGRAW (Edna De(Graw)	2. DATE OF DEATH DAY	YEAR 3. TIME OF DEATH 1995 3 - 0 4 PM
	20	SEX 6. AGE (in yrs. in:		DER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	BIRTHPLACE (State or Foreign Country Marryland
œ	9s. FACILITY NAME (If not institution, give street		9b. C	ITY, TOWN OR LOCATION OF D		C. COUNTY OF DEATH
DIRECTOR	Good Samaritan Hosp	ital		Baltimore Cit	y	
DIRE	Maryland Baltime	ore		n on Location rkville		10d, INSIDE CITY LIMITS? 1 □ YESXXIX NO
	10e. STREET AND NUMBER		1 1 4.	101. ZIP CODE	10	og. CITIZEN OF WHAT COUNTRY?
FUNERAL	2506 Taylor Avenu	. WAS DECEDENT EVER IN U.S. AS	MED I	21234 13. WAS DECENDENT OF HISPA	MC OBIONA (Facility Value)	NO. 14. RACE — American Indian.
В	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2 1 F YES, GIVE WAR OR DATES	NO	If yes, specify Cuben, Mexico	n. Puerto Rican, etc.)	14. HALE — American Indian, Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade com	(G	ECEDENT'S USUAL live kind of work do b. Do NOT use retire	ne during most of working	16b. KIND OF BUSINE	SS/INDUSTRY
MPL	Elementary/Secondary (0-12) c. 12th grade	ollege (1-4 or 5+)	Housewi		Homemaki	ing
00	17. FATHER'S NAME (First, Middle, Lest) Samuel Edward Wi	loon			AME (First, Middle, Maiden Surn	iame)
TO BE	19a. INFORMANT'S NAME (Type/Print)	19		ESS (Street and Number or Rural		
F	Mr. Maurice T. De			lor Avenue Ba		
	1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State cametery, cre	ematory or other ple	ce) Ory Inc. 3/		i mana Md
8	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE	3 02 01110 0	22. NAME AND ADDRESS OF FA	CIUTY	more, Md.
_	Holyn - Brand			7401 Belain 1		
	23. PART I. Enter the diseases, or com- shock, or heart failure. List IMMEDIATE CAUSE (Finel	plications that caused the de only one cause on each line	eath. Do not en	ter the mode of dying, suc	th aa cardiac or respirato	Approximate interval Between Onset and Death
	disease or condition resulting in death)	END-ST		CHF		
		DUE TO (OR AS A CONSE		CARDION	DAYODATH	1
RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSE	QUENCE OF):	11500	Busch	•
FIC	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSE	LEZE QUENCE OF):	MEHRI	BLOCK	
ш 1	resulting in death) LAST					-
AL C	PART II. Other significent conditions co	ontributing to death but not	resulting in the	underlying cause given in	Part I. 24s. WAS AN AUTO PERFORMED	
MEDICAL					1 YES 2	Of BEATH
						1 Tes 2 No
PHYSICIAN:		OSPITAL:	ОТН		1	
энх	1 VES 2 NO 1 1	Dispatient 2 ER/Outpatient 3 28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	1 28c. INJURY AT WORK?	8 Other (Specify) 28d. DESCRIBE HOW INJUI	RY OCCURED
BY	1 Natural 5 Pending 2 Accident Investigation		M	1 YES 2 NO		
TED	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY — At he building, etc. (Specify)	ene, refm, street, f	весогу, отнев	28f. LOCATION (Street and A City or Town, State)	Number or Rural Route Number,
COMPLETE		i: To the best of my knowledge, den				as stated.
B	29b. SIGNATURE AND TITLE OF CERTIFIER	YSICIAIN		29c. LICENSE NUI		d. DATE SIGNED (Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO CO		M 07 (7 0:-1)	Vidua Rh		2/2/1/12



1 - FOR STATE REGISTRAR

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2	TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely for be filed within 72 hours after death with the State Deot, of Health and Mental Hyglene prior to burial, cremation	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, th
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29b. SIGNATURE AND TITLE OF CERTIFIER

31. DATE ELED (Month, Day, Year) MAR 3 1 1993

CHERUKOTH V. J. VERGHESE, M.D.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REMISTRAN'S SIGNATURE
JUNA DEWY COM PONTON

		ISAAC ELSV		5. SEX	6. AGE	(In yrs. last	t birthday)	IF UNDER	1 YEAR	IF UNDER 2	M/A HRS. 7. D	ATE OF BI	30, 10	993 0. Bi	RTHPLA	S: 05 CE (State of
P	1	227-24-378		1 XX 2 □ F	(66	YRS.	MONTHS	DAYS	HOURS	100	TOBE	R /,19	26VI		
2, 3 should	DIRECTOR	99. FACILITY NAME (If not in VA MEDICAL	L CENTI							OWARD	N OF DEATH			BALTI		
Jes 1,	EC	RESIDENCE OF DEC	10b. COUNTY	1			10c. CIT	, TOWN (R LOCAT	TION					100	I. INSIDE C
permit. Pages 1,		MARYLAND	BALT	IMORE COL	JNTY		BAL	IMOI	_							LIMITS?
- <u>FS</u>	FUNERAL	1612 FOUR G	EORGES							2122			Į	J.S.A		COUNTRY
by the hospital or attending physician, be detached for use as the burial-transit at once.	BY	11. MARITAL STATUS 1 Never Married 2 3 Divid		12. WAS DECEOEN FORCES? 1 IF YES, GIVE V	YES	2XXN ATES 30/4	MED OWW2 7		If yes, sp	ENDENT OF ecify Cuben, 2 XNO	, Mexican, Pu	RIGIN? (Spi orto Ricen,	etc.)	В	ACE — / llack, Wr pacify:	American II hite, etc.
r atten use as	Ð		EDENT'S EDUC y highest grade			(Gi	CEDENT'S	rork done		ON est of working		16b. KIND	OF BUSINES	S/INDUSTR	Y	
ched for e.	COMPLET	Elementary/Secondary (C		College (1-4 or 5	+)		NE OI		TOR			STEE	IL MANU	JFACT	URII	NG
	BE CO	17. FATHER'S NAME (First, M ISAAC ELSWIC	CK							424 1124 11			(WEBB)			
5 should	2	19a. INFORMANT'S NAME (1											y or Town, Stel			
page t		CLINICAL REC	ION		20b		A L'ILI					-	RD, MI			State
ge 6 ma irector, p r must		1 Regural 2 Cremation 3 Removal from State Cometery Crematory of Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND AD									1	1/2		Balt		
hours after death, Page 6 may be retained I ed in by the funeral director, page 5 should or removal. medical examiner must be notified		21. SIGNATURE OF FUNERA	L SERVICE LIC	Cm	rel	O Qu	1_			llv	Funer	al	Home	of I	una	dalk
ic at		23. PART I. Enter the d	iseases, or c	complications the	t caused	the tie	nth. Do n	ot enter	the mo	de of dyln	g, such as	cardiac o	r reaplrator	y arrest,	1K	Approx
rted within 24 hours completely filled in ial, cremation, or ri event, the mec		IMMEDIATE CAUSE (Fir disease or condition resulting in death)	nal	. SEVERE	CHR	ONIC			ΓΙVΕ	PULM	ONARY	DISE	ASE			Onset a
and con burial,	TION	Sequentially list condit if any, leading to imme	diate	b			UENCE OF									
he death certificate be e the attending physician Mental Hygiene prior to njury, or other traum	CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST														
the death the atte d Mental Injury, o		PART II. Other significa	nt condition	s contributing to	death h	ut not re	aultino I	n the un	dadula	n course of	use le Bart		WW 0 AN ALESS	nov I		
	IS	ARTERIOSCLE					rauling i	ii the un	deriying	g cause gr	ven in Part	- 1	PERFORMED?		AMA	RE AUTOPSY JLABLE PRI MPLETION O
2 0 0 0	: MEDICAL	NON-INSULIN	DEPEN	DENT DIA	BETE	S ME	LLIT	JS				'	YES 2 X N			DEATH?
he law has b e Dept.	SICIAN	25. WAS CASE REFERRED TO	O MEDICAL						26. PL	ACE OF OE	ATH (Check on	ly one)				
TIME T	YSIC	EXAMINER? 1 YES 2 NO		HOSPITAL:	☐ ER/Outp	etlent 3	□ DOA	OTHER 4 Num		e 5 🗆 Resi	Idence 6 🗆	Other (Spec	offy)			
NG PHYSICIAN: The law in fler this certificate has be that with the State Dept.	РНҮ	27. MANNER OF OEATH 1 Natural 5	Pending	26a. OATE OF (Month, E			28b. TIMI INJ	OF JRY		RK?		OEȘCRIBE	HOW INJURY	OCCURED		
DR ATTENDING P DIRECTOR: After to hours after death v item 28 is mari	ED BY	3 Suicide 6	Could not be determined	28e. PLACE C building,	F INJURY	— Al hor	ne, lerm, s	treet, lact		YES 2 🗌	281.	LOCATION City or Town	(Street and Nu n, State)	mber or Rui	ral Route	Number,
DIRECT HOURS A Item 2	PLET	29a. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the best of	my know	ledge, øler	ith occurre	d at the t	lme, date	end place.	and due to the	cause(e)	end menner =	s stated.	_	
HOSPITAL UNERAL WITHIN 72	OMI	41		R: On the beets of e					-						se(e) end	d menner e
7 75 5		Control of the Control			- /-	11	-									

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

93 08612

m, in my opinion, death occured at the time, date and place, end due to the cause(e) and menner se stated.

29c. LICENSE NUMBER

CHERUKOTH V. J. VERGHESÉ, M.D., VA MEDICAL CENTER, FORT HOWARD, MD 21052

3. TIME OF DEATH

8:05 B. BIRTHPLACE (State or Foreign Country)

> 10d. INSIDE CITY 1 TES 2 ANO

14. RACE — American Indian, Black, White, etc.

WHITE

Approximate Interval Between Onset and Death **YEARS**

24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

▶ 3/30/93

1993

9c. COUNTY OF DEATH

Baltimore

10g. CITIZEN OF WHAT COUNTRY?

Specify

United States

14. RACE — American Indian,

3. TIME OF DEATH

10d. INSIDE CITY

1 🗌 YES 2 💢 NO

White

21206

Approximate Interval Between Onset and Death

Virginia

27

16b. KIND OF BUSINESS/INDUSTRY

Own Home

Overlea, Maryland

20c. LOCATION — City or Town, State

Dorsey, Maryland

Dundalk Maruland 21222

"3=20-1897

3

21206

DATE

7. DATE OF BIRTH

MELETED

32. BEGISTRAR'S SIGNATURE whia Davidson

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

26d. DESCRIBE HOW INJURY OCCURED 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)

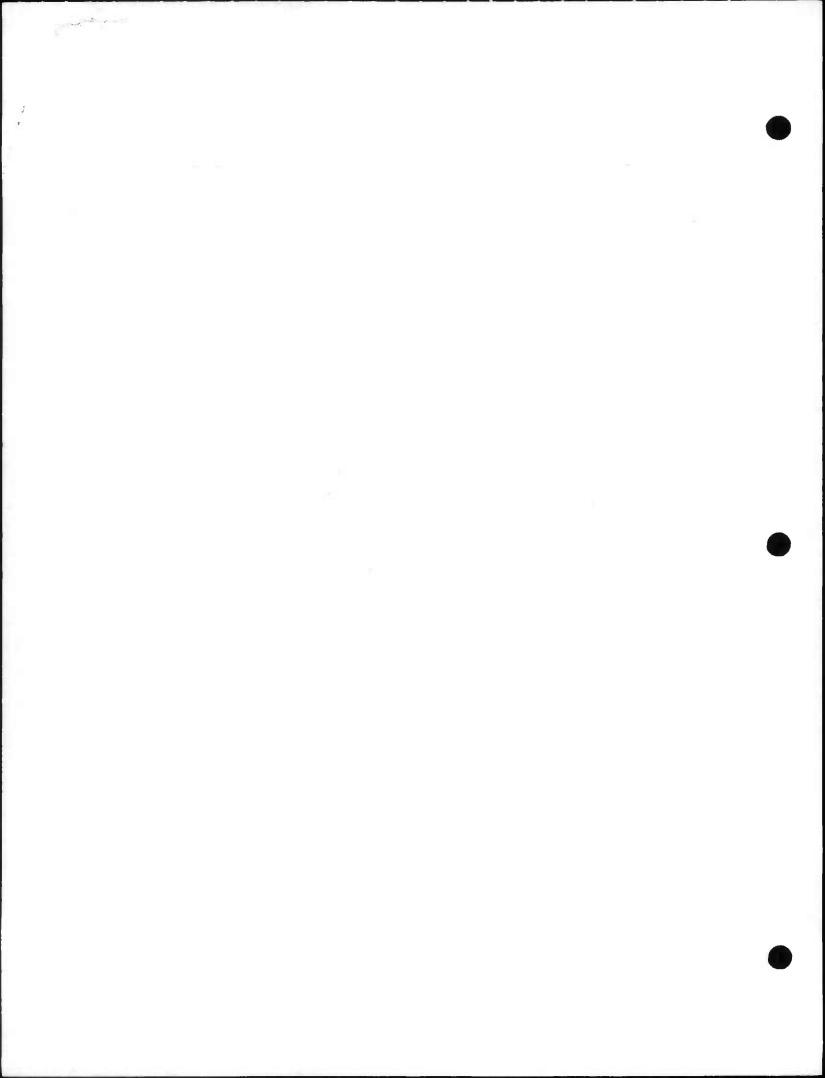
atigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated. 29d, DATE SIGNED (Month Day Year)

PERFORMED?

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Station slive 26

DHMH-16 Ray 1/89



use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760, HOSPITAL OR ATTENDING PHYSICIAN: T. 出

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93 08614 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF OEATN YEAR DOROTHY FAULCON 93 4. SOCIAL SECURITY NUMBER 5. SEX S. BIRTNPLACE (State or Foreign Country) 6. AGE (In yrs. last birthday) 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR | IF UNDER 24 HRS 1 🗌 M 2 🙀 F DAYS HOURS MIN 240-54-0802 YRS. 5-18-30 N 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN DIRECTOR 1825 RIGGS AVENUE BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD XX YES 2 NO BALTIMORE FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 1825 RIGGS AVENUE 21217 U.S.A. 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2/3/10 13. WAS OECENOENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried FORCES? 1 YES ZYNO II yes, specify Cuben, Mexican, Puerto Ri 1 — YES 2 X NO Specify: BY Specify 3 🕅 Widowed 4 🗌 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 18e. OECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INQUISTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 12th DISABLED 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) DAVID BELLFIELD BE MOLLIE MILLS 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ACORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 WILLIAM BLAND JR. F.H. 1500 ARLINGTON ROAD/HOPEWELL, VA23860 20a, METHOD OF DISPOSITION
1 🖄 Burlal 2 🗆 Cremetion 3 🗀 Ramoval from State
4 🗆 Donation 5 🗀 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE FAULCON FAMILY CEMETERY ROANOKE RAPIDS, NC 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY emand WM.C.MARCH F.H./1101 E. NORTH AVE. 23. PART i. Enter the disesses, pr comprications that caused the desth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feliure. List only one cause on sach lins. Approximate interval Between **IMMEDIATE CAUSE (Fine)** Onset and Death FULCAL SEPS(S)
OUE TO (OR AS A CONSEQUENCE OF): disesse or condition resulting in desth) 90UTE MYELOID LEUKEMU CERTIFICATION Sequentielly list conditiona, OUE TO (OR AS A CONSEDUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a, WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 TES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

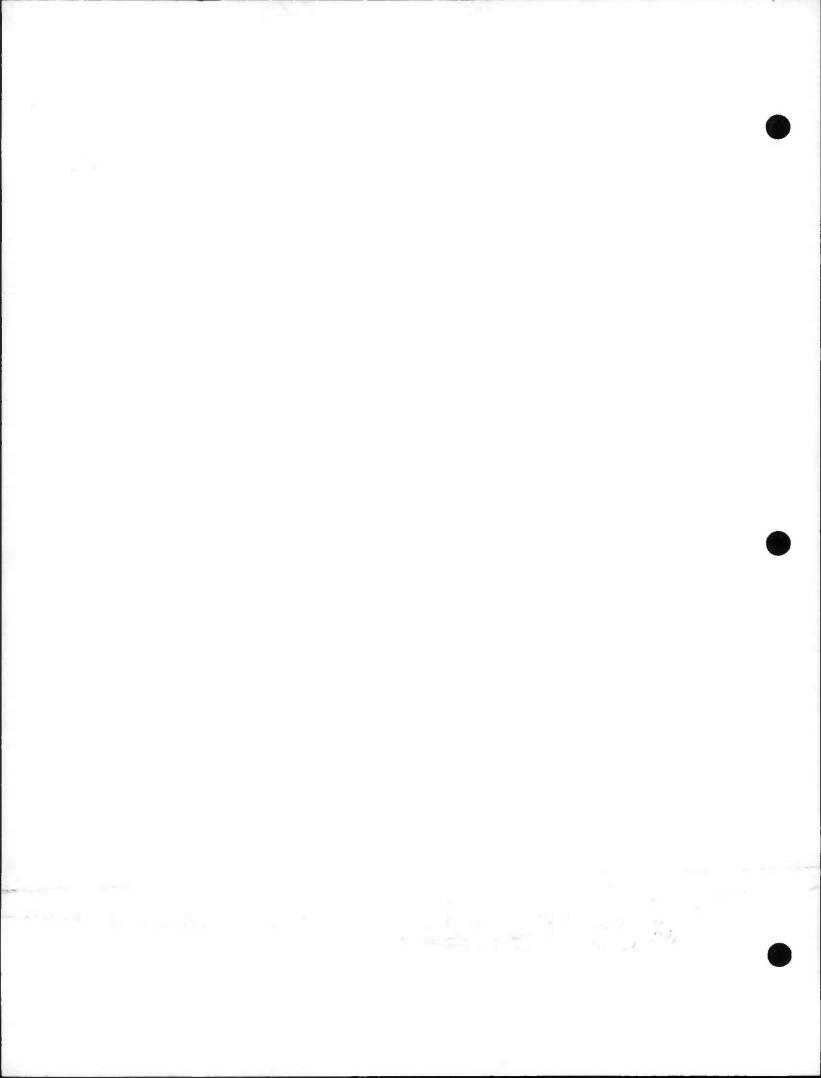
1 YES 2 26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER:

Natural 5 Pending 2 Accident Investigation	28s. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	284. DESCRIBE HOW INJURY OCCURED
3 Suicide S Could not be determined	28e. PLACE OF INJURY — At hor building, etc. (Specify)	me, farm, street, lac	tory, office	28f. LOCATION (Street end Number or Rural Route Number, City or Town, State)
one)				to the cause(e) and manner ee stated.

Residence 8 - Other (Specify)

29b. SIGNATURE AND TITLE OF CLETIFIER 29c. LICENSE NUMBER	29d. OATE SIGNED (Month, Day, Year)

/ //	1 0/1			((/	1 '	
30. NAME AND ADDRESS OF PERS	ON WHO COMPLETED CAUSE OF DE	MTH STEM 27) (NOS. P.	THE PARTY			
ANTONIO	WOLFF, MO	- 60C	N. WOLFE	ST	BALTIMOR	E 21287
	32 HEGISTRAR'S BO				-	



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

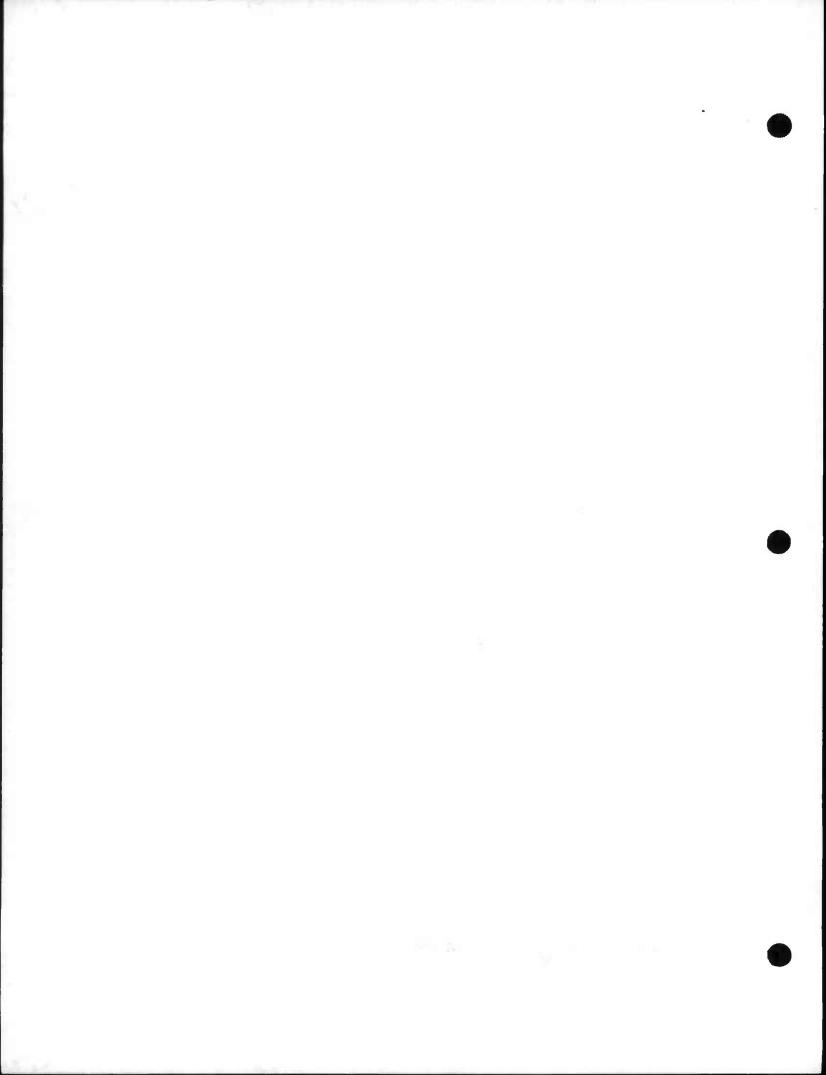
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	FOR	CTATE DE MADVI	AND / DE	DA DTHAFA	T DE U	F44711 4410			9:	3 0	18615
	1 - STATE REGISTRAR	STATE DF MARYL	AND / DE	TIFICAT	E OF	DEATH	MENTA	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)							E OF DEATH		3.	TIME OF DEATH
1	Doro	thy J. Fal	ls				MON.	тн в -28-9		YEAR	130A "
	4. SOCIAL SECURITY NUMBER	(In yrs. last birtl		ER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH 8. BIRT			. BIRTHPLA	ICE (State or Foreign	
	216-18-9698	70 v			HOURS MIN.	4	th, Day, Year) -30-2	2 F	enns	sylvania	
ac	9e. FACILITY NAME (If not institution, give s					R LOCATION OF D	EATH		9c. COUNT	Y OF DEATH	1
<u>E</u>	1403 W. 37t]			Salt]	more						
DIRECTOR	10e. STATE 10b. COUNTY	Y	100	c. CITY, TOWN	OR LOCAT					100	I. INSIDE CITY
1 1	Maryland					Ва	11ti	more		10	LIMITS?
AL I	10e. STREET AND NUMBER				10f.	ZIP CODE			10g. CITIZE	N OF WHAT	COUNTRY?
삘		h Street					212	11	Į	J.S.A	1.
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER I	2 X NO	13	It yes, spe	ENDENT OF HISPA Helfy Cuban, Mexic	an, Puerto		or No 1	Black, Wi	
B	3 T Widowed 4 Divorced	IF YES, GIVE WAR OR D	PATES	1	1 YES	2 NO Speci	ify:			Specify:	white
COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade	CATION completed)	16e. DECEDE	ENT'S USUAL	OCCUPATIO	IN at wasting	16	b. KIND OF BU	SINESS/INOUS		
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do N	VOT use retired.)	st or working		mb o a	+ ~ ~ (iomn-	
₩	12th		800	kkeer	ет			inea	ter (ompa	шу
	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA					
닒	Harry Morrow 190. INFORMANT'S NAME (Type/Print)							Thomp			
2	THE STATE OF THE S					nd Number or Rural					21211
	Suzanne Cianfe:		-	12 W.	_	th Stre			imore		21211
	1 N Buriel 2 ☐ Cremetion 3 ☐ Remoted ☐ Donation 5 ☐ Other (Specify)	oval from State	netery, cremator	ry or other place	SITION (Nai	me of	3/31		CATION — CH		sum. sylvania
	21. SIGNATURE OF FUNERAL SERVICE LIC		IC. KC	22	NAME AN	O ADDRESS OF E	ACH ITY				Sylvania
	Slaus X	1. Cuses	nter			ee-Hens			1 Hon 1timo		MD 2121
	23. PART I. Enter the diseases, or o	complications that cause	d the deeth.	Do not enta	r the mod	de of dying, auc	ch ss cer	diac or respi			Approximata
	immediate cause (Final	List only one cause on a	ech line.	/							Interval Between Onset and Death
	disease or condition resulting in death)	Brai	11 7	le hi	Dr.						Comonthe
		DUE TO (OR AS	CONSEQUEN	CE OF):							4 HORICE
N.	Sequentially list conditions,	b									
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUEN	CE OF):							
윤	CAUSE (Disease or injury that initieted events	DUE TO (OR AS A	CONSEQUEN	CE OE)							
ᇤ	resulting in death) LAST			or 017.						į	
빙		1									
AL.	PART II. Other significent condition	e contributing to deeth b	out not recuit	ting in the u	ınderiying	ceuse given in	Part i.	24a. WAS AN PERFOR			RE AUTOPSY FINDINGS
MEDICAL								1 TYES 2	The second second	CON	MPLETION OF CAUSE DEATH?
M										1 [YES 2 NO
PHYSICIAN:	OF MAC CACE DESCRIPTION TO MESSAGE										
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHE		ACE OF DEATH (C)	heck only o	ne)			
₹	1 YES 2 HO	1 Inpatient 2 ER/Outs 28e. DATE OF INJURY			7	5 Pesidence	_				
	1 Netural 5 Pending	(Month, Day, Yeer)	200	INJURY	28c. INJU WOF	RK? ES 2 NO	28d. DE	SCRIBE HOW II	NJURY OCCUI	REO	
84	2 Accident Investigation 3 Suicide 8 Could not be	26e. PLACE OF INJURY	- At home, to	erm, street, fac		E3 2 NO	281 1.00	ATION (Street e	and Number or	Purel Doube	Mumbae
回	4 Homicide 8 Could not be determined	building, etc. (Spec	cify)				City	or Town, State)	THE THE THE CO	HUTEL HOUSE	ivamos,
J.E	29e. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my know	ledge, death ~	coursed at the	time date	and place and 4	to the c				
COMPLET		R: On the beele of examination									menner ee stated
N N	29b. SIGNATURE AND TITLE OF CERTIFIER			0		29c. LICENSE NU		,	-		
ω	(Hole L	1. 11 10	/ /	11/1	5	7 7 A	()	5_	Zya. DATE S	S -S	nth, Day, Year)
2	30 NAME AND ADDRESS OF REPON WHO	3 1 1 1 1 1	7/	W	/	1100	3/2		- 3	130	1193

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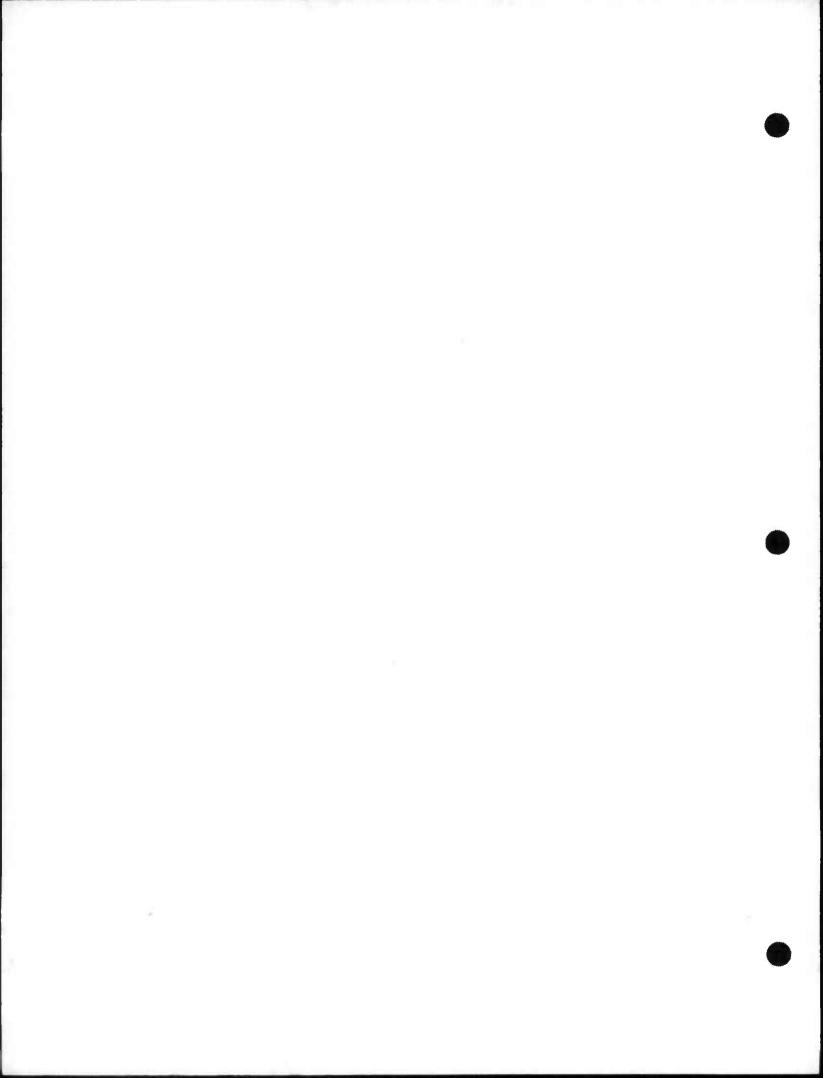
Posey

30. NAME AND ADDRESS OF Dr. John



contract the task of the first of the first of the first of the first of the first of allenging physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	9000
y ne retailled by	age 5 should be	he notified at
Jeans, raye of me	funeral director, p	or item 23 shows any injury or other traumatic event, the medical examiner must be notified at eace
E- Hours aren	ly filled in by the ation, or removal.	the medical
oc cycooled within	ian and completel or to burial, crema	sumatic event
חסמנון בכן ווווכפור	s certificate has been signed by the attending physician and completely filled in by the th the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ury or other tr
מממונים מוומי מוני	een signed by the	shows any inju
COOLER INC IGN	certificate has b	d. or item 23
	ECTOR: After this is after death with	n 28 is marke
The moon like on the leading	TO THE FUNERAL DIRECTOR: After this cert be filed within 72 hours after death with the	(PORTANT: If Item 28 is marked.
3	P eq	2

	1 - FOR STATE REGISTRAR	STATE OF MARYLAI		MENT OF H		MENTAL HYGIENE REG. NO.	93	08616		
	1. DECEDENT'S NAME (First, Middle, Last) Lida	E. GROVEF	₹			2. DATE OF DEATH 2.54 March 26.	1993EAR	3. TIME OF DEATH 10:22 a M		
	4. SOCIAL SECURITY NUMBER 213–20–5595	1 □ M 2 💥 = 90	YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan. 12. 19	03 Mar	rvland		
CTOR	98. FACILITY NAME (If not Institution, give street and number) 99. CITY, TOWN OR LOCATION OF DEATH 90. COUNTY OF DEATH PARTIES OF DECEDENT 90. COUNTY OF DEATH 90. COUNTY OF DEATH BAITIMOY RESIDENCE OF DECEDENT									
DIRECTOR	Md .	Baltimore	10c. CITY,	TOWN OR LOCAT	Perry	Hall		10d. INSIDE CITY LIMITS? 1 YES 2XXNO		
FUNERAL		E. Joppa Rd.				236	10g. CITIZEN OF W			
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 Tyes IF YES, GIVE WAR OR DATE	2 NO	If yea, spe	ENDENT OF HISPAN ocity Cubert, Mexica 2 NO Specify	IIC ORIGIN? (Specify Yee n, Puerto Ricen, atc.)	Black,	- American Indian, , White, etc. White		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)		rk done during mo: retired.)	N st of working	16b. KIND OF BUSI				
	8 YTS. 17. FATHER'S NAME (First, Middle, Last)	hilip A. Eck	House w	176	18. MOTHER'S NA Hanna	Home ME (First, Middle, Maiden S A Dat	Sumame) Nler			
M _L	190. INFORMANT'S NAME (Type/Print) Wilbur H. Grover		19b. MAILING A 4235	E. Jop	nd Number or Rural F	Poute Number, City or Town,	State, Zip Code)			
	20a. METHOD OF DISPOSITION Burlel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	cemete FOT	LACEAND DATE OF Pry, cremetory or othe 'K U.Meth	nodist C	hurch Ce	m. 3-29-93	FOIK,			
	21. SIGNATURE OF FUNERAL SERVICE LIC	A		75.00	D ADDRESS OF FA	E.F.Las Rd. Kingsv	ssahn Fur Ville, Mc	eral Home 1. 21087		
CERTIFICATION	23. PART I. Enter the diaeasea, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	infarci	tion		s as cardiac or reaping		Approximate Interval Between Onset and Death			
PHYSICIAN: MEDICAL CER	PART II. Other algorificant condition	a contributing to death but Arthritis History of			cause given in	Part I. 24s. WAS AN A PERFORM 1	MED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatie		OTHER:	ACE OF DEATH (Che					
BY PHYS	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c. INJU		8 ☐ Other (Specify) 28d. DE\$CRIBE HOW IN.	JURY OCCURED			
	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, ferm, stre	eet, fectory, office		2af. LOCATION (Street an City or Town, State)	d Number or Rural Ro	oute Number,		
COMPLETED		CIAN: To the best of my knowledge. R: On the beets of examination en						end manner ee stated.		
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Kelleera			29c. LICENSE NUM		29d. DATE SIGNED	Month, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO Dr. Edith Rivera 31. DATE FILED (Month, Day, 16ar)			Drive E	Balto, Mo	1. 21237				
	MAR 3 1 1993	ic Landon Byde	M.							



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

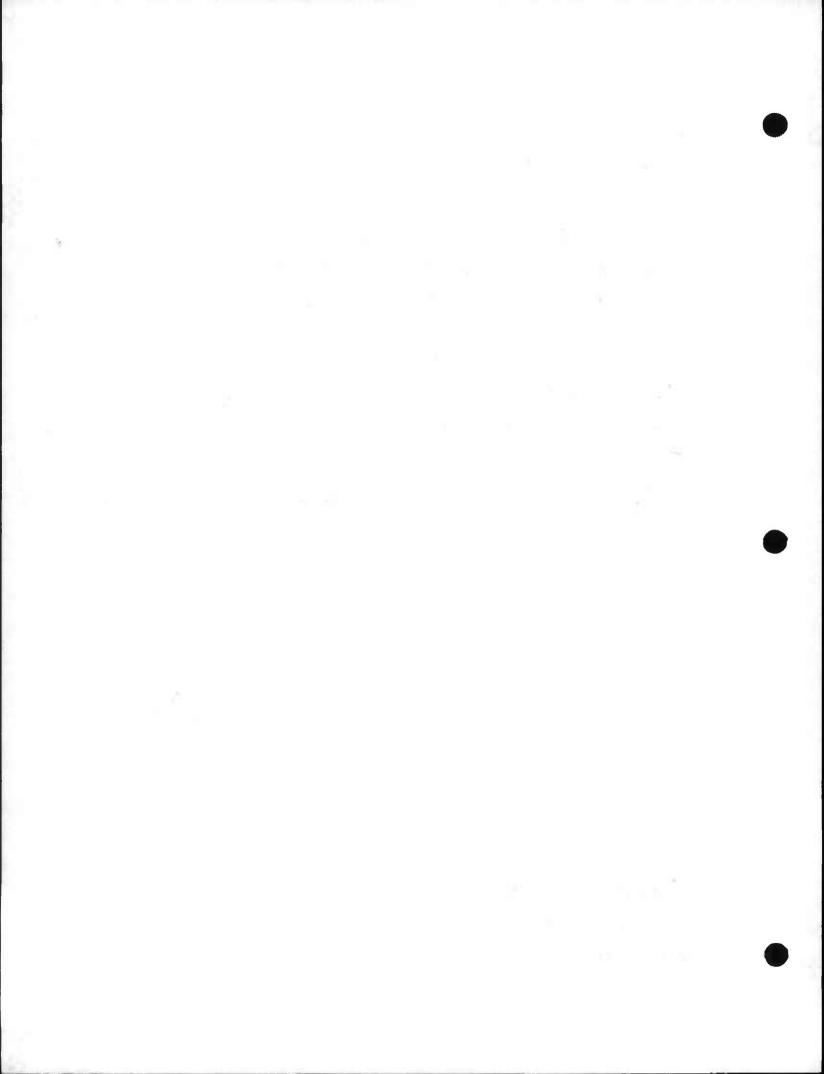
	1 - FOR STATE REGISTRAR	STATE OF MAR	RYLAND / DEF	PARTMENT OF	HEALTH AND	MENTAL HYGIEI			
	1. DECEDENT'S NAME (First, Middle, Last	*				2. DATE OF DEATH		3. TIME OF DEATH	
	James Thomson					March 2	7 1993	8:22 A.	
	4. SOCIAL SECURITY NUMBER 078-18-6250	5. SEX 6. /	AGE (in yrs. last birtho	MONTHS DAVE	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)	
	9a. FACILITY NAME (If not institution, give		69 "		OR LOCATION OF D	Sept.26,1	923 S	Scotland	
OR	Fallston Gene	ral Hospita	1		allston			rford	
<u>E</u>	RESIDENCE OF DECEDENT 10e. STATE 10b. COUN			CITY, TOWN OR LOCA			110		
DIRECTOR	Maryland H	arford		Abingde				10d. INSIDE CITY LIMITS? 1 YES 2 Y NO	
	10e. STREET AND NUMBER				Of. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
FUNERAL	201 Star Point				21009			J.S.A.	
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEOENT EV FORCES? 1	YES 2 X NO	If yes, a	pecify Cuben, Mexica	NIC ORIGIN? (Specify Youn, Puerto Rican, etc.)	ne or No 14.	RACE — American Indian, Black, White, atc.	
В	3 Widowed 4 Divorced	IF YES, GIVE WAR (OR DATES	1 🗆 YE	S 2 🔀 NO Specif	y:		Specify: White	
ETED	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)	16a, OECEDER (Give kind	IT'S USUAL OCCUPATI	ION lost of working	16b. KIND OF BU	JSINESS/INDUST		
Ę	Elementary/Secondary (0-12) N/A	College (1-4 or 5+)	Itte. Do No	OT use retired.)	-				
COMPL	17, FATHER'S NAME (First, Middle, Lest)	N/A	Barge	Dispatche		EX:	xon		
ш	John Giles				Margar		dleton		
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAII	ING ADDRESS (Street		Route Number, City or To		de)	
F	Laura D. Giles	(wife)	20:	Star Poi	inte Ct.,	Apt. 2A, A	oingdon	, MD 21009	
	20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Re 4 Donetion 5 Dother (Specify)	moval from State	20h PLACEANODA	TEGEDISPOSITION /A	lame of	0ATE 200 14	CATION CH	or Town State	
ï	altimor	e, Maryland							
	1 /2.	7 7		Schin		eral Homes			
73	23. PART I. Enter the diseases, or	complications that car	used the death, I	o not enter the me	Belair R	toad, Balt:	imore,	MD 21236 Approximate	
	shock, or heart failure IMMEDIATE CAUSE (Final	. List only one cause of	on each line.					Interval Betw	
	disease or condition resulting in death)	8.	CONOS	ACCIN	254	Cin			
	disease or condition resulting in death) a. CONSMO WASCUM ACCINENT OUE TO (OR AS A CONSEQUENCE OF): ATT DOUG SCUSSION TO VASCUM WIS OUE TO (OR AS A CONSEQUENCE OF):								
0	Sequentially list conditions,	b. OUE TO (OR	OUE TO (OR AS A CONSEQUENCE OF):						
CAT	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	C						İ	
E	that initiated events resulting in death) LAST	DUE TO (OR	AS A CONSEQUENC	E OF):					
CERTIFICATION		d							
ÄL	PART II. Other significant condition	one contributing to dea	th but not resulti	ng in the underlyin	ig cause given in	Part I, 24a, WAS AI	AUTOPSY RMED?	24b. WERE AUTOPSY FINDIF	
MEDIC						1 🗆 YES	2 🗌 NO	OF DEATH?	
Σ						_		1 TYES 2 NO	
SICIAN:	25. WAS CASE REFERRED TO MEDICAL			28. P	LACE OF DEATH (Ch	eck only one)			
VSIC	1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/	Outpatient 3 🗆 DO	OTHER:	ne 5 Residence	8 Other (Specify)			
PHY	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJU (Month, Day, Ye			JURY AT	28d. DESCRIBE HOW	INJURY OCCUR	ED	
à	2 Accident Investigation		H IPPO AA A A A A A A A A A A A A A A A A A	M 1					
	3 Suicide 8 Could not be determined	building, etc.	28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)				end Number or F	Bural Route Number,	
9	29e. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of my k	consisting death oc	turned at the time, date	and alone and due	to the country and			
COMPLET								euse(e) end menner ea stated	
u II	296. SIGNATURE AND THE OF CENTY		1	,	29c. LICENSE NUI			GNED (Month, Day, Year)	
ן מ	Marla	4.11		Nos	02	0390	> 3	129/93	
임	30. NAME AND ADDRESS OF PERSON W				100	N-11	-		
- 1	Dr. Charles Hoes	cn, 9/12 Be	lair Rd.	Suite 2	03 Pal+	imoro MD	21236		
	31. DATE FILED (Month, Day, Year) MAR 3 1 1993	32. AEGISTRAR'S S	SIGNATURE	, Duite 2	OJ, Dail	Inore, In	21230		

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE OF MARYLAND / DEPART CERTIFIC	MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIENE REG. NO.	3 000:0
- 2	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday)	HOOKER	3 2.7	1993 10.27 Am
		MONTHS DAYS HOURS MIN.	(Month/Day, Year) /4	8. BIRTHPLACE (State or Foreign Country)
		9b. CITY, TOWN OR LOCATION OF D	7 7 7 7	COUNTY OF DEATH
D.	CITGO-1200 EAST NORTH AVENUE	BALTIMORE	CITY	
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY,	TOWN OR LOCATION	+>	10d. INSIDE CITY LIMITS?
		KAWdLL5	lowed	1 YES 2 NO
FUNERAL	9707 MENDOZA Rd	101. ZIP CODE	109	CITIZEN OF WHAT COUNTRY?
E. N	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 2 NO	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxico	NIC ORIGIN? (Specify Yea or No	14. RACE — American Indian, Black, White, atc.
ВУ		1 WES 2 NO Specific		Specify: BIACK
<u>E</u>	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of wc	SUAL OCCUPATION	16b. KIND OF BUSINES	S/INDUSTRY
J.E	Elementary/Secondary (0-12) College (1-4 or 5+)	ork done during most of working retired.)	and H. U	merelle,
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	M. MOTHER'S N	ME (First, Middle, Maiden Surna	ne))
BE C	WALLACE MOOKER	DORI	5 WASHI	NglaN
2		ADDRESS (Street and Number or Rural	Route Number, City or Town, State	1 1
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF		DATE 20c. LOCATIO	Md (21212 N - City or Town, State
	1 Surial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify)	ALLN Cen.	41/ Bali	o County md
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FA	1	A D to a DV
	22 DAN Lester the discourse of a published the state of t	Joeks Thomas	None 1304	N-CENTRAL AYL
	23. PART L'Enter the diseases, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.			interval Between
	disease or condition resulting in death) A FER USC LUM	tic Cardior	19 sculus DI	xease
	DUE TO (OR AS A CONSEQUENCE OF):			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate Due TO (OR AS A CONSEQUENCE OF):	:		
ICA	cause. Enter UNDERLYING CAUSE (Disease or injury			
F	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST			
	PART II. Other significant conditions contributing to death but not resulting in	the randerlying series along to	Book 5 An inches	
ICAL		the underlying cause given in	Part i. 24a. WAS AN AUTO PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME			TA YES 2	OF DEATH?
4			- +M34	24/10
2				
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Types 2 NO	26. PLACE OF DEATH (Ch		CO CISTATION
HYSICIAN	EXAMINER? 1	OTHER: Nursing Home 5 Residence Residence State	GO-SERVICE	
BY PHYSICIAN	EXAMINER? 1	OTHER: Nursing Home 5 Residence OF 28c. INJURY AT WORK? N YES 2 NO	eX☐ Other (Specify) CIT	GO-SERVICE
TED BY PHYSICIAN: MEDIC	EXAMINER? 1 XYES 2 NO	OTHER: Nursing Home 5 Residence OF 28c. INJURY AT WORK? N YES 2 NO	eX☐ Other (Specify) CIT	OCCURED
	EXAMINER? 1 XYES 2 NO 27. MANNER OF DEATH 1 Aetural 5 Pending investigation 3 Suicide 8 Could not be determined 28. PLACE OF INJURY At home, larm, str building, stc. (Specify)	OTHER: Nursing Home 5 Rasidenca OF 28c. INJURY AT WORK? N	eXI Other (Specify) CIT 28d. DESCRIBE HOW INJURY 281. LOCATION (Street and Nu City or Town, State)	OCCURED The or Rural Route Number,
MELETED	EXAMINER? 1	OTHER: Nursing Home 5 Rasidenca	eX Other (Specify) CIT 2ed. DESCRIBE HOW INJURY 2el. LOCATION (Street and Nu City or Town, State)	OCCURED mber or Rural Route Number, stated.
COMPLETED	EXAMINER? 1 XYES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred	OTHER: Nursing Home 5 Rasidenca OF 28c. INJURY AT WORK? No	eX Other (Specify) CIT 28d. DESCRIBE HOW INJURY 28l. LOCATION (Street and Nu City or Town, State) to the cause(s) and manner at time, data and placa, and due ABER 29d.	GO - SERVICE OCCURED mber or Rural Route Number, stated. Io the cause(a) and manner as stated. DATE SIGNED (Month, Day, Year)
MELETED	EXAMINER? 1 XYES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER 1 Nostination Nostination Nostination Nostination 1 OCERTIFIER Check only one) 29c. SIGNATURE AND TITLE OF CERTIFIER 1 Impatient 2 ER/Outpatient 3 DOA 28c. DATE OF INJURY 28b. TIME (Month, Dey. Year) 28c. PLACE OF INJURY — At home, larm, str building, stc. (Specify) 28c. PLACE OF INJURY — At home, larm, str building, stc. (Specify) 28c. PLACE OF INJURY — At home, larm, str building, stc. (Specify) 29c. SIGNATURE AND TITLE OF CERTIFIER	OTHER: Nursing Home 5 Rasidenca	eX Other (Specify) CIT 28d. DESCRIBE HOW INJURY 28l. LOCATION (Street and Nu City or Town, State) to the cause(s) and manner at time, data and placa, and due ABER 29d.	GO - SERVICE OCCURED mber or Rural Route Number, i stated. Io the cause(a) and manner as stated. DATE SIGNED (Month, Day, Year)
BE COMPLETED	EXAMINER? 1 XYES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, larm, str building, stc. (Specify) 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, P.	OTHER: Nursing Home 5 Rasidenca	eXI Other (Specify) CIT 2ed. DESCRIBE HOW INJURY 2el. LOCATION (Street and Nu City or Town, State) to the cause(a) and manner at time, data and placa, and due ABER 29d.	GO - SERVICE OCCURED mber or Rural Route Number, stated. lo the cause(s) and manner as stated. DATE SIGNED (Month, Day, Year) 3 28 1993
BE COMPLETED	EXAMINER? 1 XYES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, larm, str building, stc. (Specify) 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, P.	OTHER: Nursing Home 5 Rasidenca	eXI Other (Specify) CIT 2ed. DESCRIBE HOW INJURY 2el. LOCATION (Street and Nu City or Town, State) to the cause(a) and manner at time, data and placa, and due ABER 29d.	GO - SERVICE OCCURED mber or Rural Route Number, stated. lo the cause(s) and manner as stated. DATE SIGNED (Month, Day, Year) 3 28 1993



DIVISION OF VITAL RECORDS, P.O. BOX 68760, HOSPITAL OR ATTENDING PHYSICIAN: The Jam

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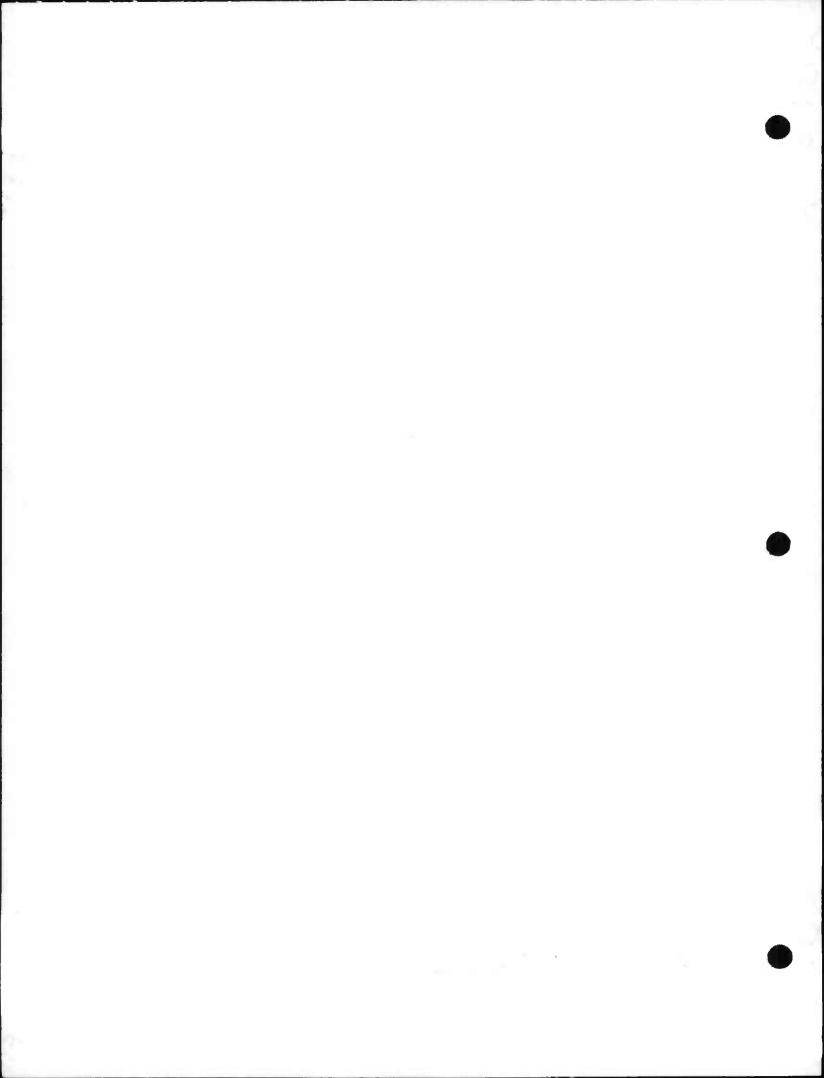
cuted within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ge 5 should be detached for use as the burial-transit permit Pages 1 2 3	2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	led at once.
Page 6 may be re	director, page 5		er must be no
ours after death. F	ompletely filled in by the funeral	or removal.	rked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
uted within 24 ho	completely filled	nial, cremation, c	c event, the n
ertificate be executed v	ing physician and	rgiene prior to bu	other traumati
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The law requires	ite has been sign	eath with the State Dept. of Health an	ет 23 shows
ING PHYSICIAN:	After this certificate has bet	leath with the St	20
TO THE HOSPITAL OR ATTENDIN	TO THE FUNERAL DIRECTOR: After to	be filed within 72 hours after dea	IMPORTANT: If item 28 is n
TO THE HOSPI	TO THE FUNER	be filed within	IMPORTANT:

93 08619 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR JAMES HARRELL 3 93 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTN (Month, Day, Year) 6. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS 1 X M 2 - F 243-18-7820 80 YRS. 8-13-1 N. 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR LONG GREEN NURSING HOME BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 18c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MD BALTIMORE 1 X YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 30th 1624 E STREET 21218 S . A 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 25 TO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES ZENO 1 Never Merried 2 Merrie If yes, specify Cuben, Mexican, Puerto Ri 1 TES 2 NO Specify: В 3 Widowed 4 Divorced Specify: BLACK COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16h KIND OF RUSINESS/INQUISTRY mast of working (Give kind of work done life. Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5+) BALTIMORE CITY 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) BE OSCAR HARRELL 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 ANNER E HARRELL 1624 E 30th STREET/BALTIMORE, MD 21218 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State UNION CO. 1 ☑ Burlal 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify) CHAPEL METH CH CEM MARSHVILLE 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bernay WM.C.MARCH F.H./1101 E. NORTH AVE. moun 23. PART I. Entar the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. kist only one cause on each line. Approximata intarvai Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Cenal Fulure usks - month resulting in death) OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 YES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Nome 5 Residence 6 Other (Specify) 26e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Nomicide 29e. CERTIFIER (Check only 1 are CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated.

296. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) we D1295 an 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Blud 3601 Lock Konen 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated.



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TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-¥ nours after death. Page 6	AL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct	
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A T	E	400
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for use as the burial-transit permit. Pages 1, 2, 3 should may be retained by the hospital or attending physician. detached or, page 5 should be notified at pe must examiner medical the traumatic event, Injury, or other State Dept. of Health and Item 23 shows any 0 28 is marked, TO THE HOSPITAL OR ATTO THE FUNERAL DIRECT DE filed within 72 hours at IMPORTANT; If Item 2

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH JAMES HENRY 2. DATE OF DEATH 3-27-93 MONTH DAY YEAR 03 27 93 1. DECEDENT'S NAME (First, Middle, Last) HARTWELL, 3. TIME OF DEATH 45 A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 667 - 05-1 X M 2 - F 0 YRS 15 08-MASS 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH JOHNS HORINS GERIATRICS CENTER DIRECTOR NA 13A110 RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Harford Co Aberdeen 1 YES 2 NO FUNERAL 10e STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 468 W. Bel Air Avenue 21001 IISA 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Marri 1 TES 2 NO Specify В 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18b. KIND OF BUSINESS/INDUSTRY intery/Secondary (0-12) College (1-4 or 5+) Fed Gov't Test and Evaulation 12+ Project Engineer 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lovedale Hartwell BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Emma Hartwell 468 W. Bel Air Avenue, Aberdeen, MD 21001 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State 4 Donation 5 Other (Specify) SIGNATURE OF FUN 22. NAME AND ADDRESS OF FACILITY State Anatomy Board TRAL SERVICE LICENSES Ronald Wade, Dir 3/29/93 655W.BaltimoreSt, Balto, MD 21201 23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, shock, or heart feliure. List only one ceuse on each line. Approximate interval Between MEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) SEPSIS 4 days DUE TO (OR AS A CONSEQUENCE OF) SIP MASSIVE INTRACRANIAL HEMORPHAGE 5Mo. CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF). cause, Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other eignificant conditions contributing to death but not recuiting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? MAN ARLE PR COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 | YES 2 | WE 1 Inpatient 2 ER/Outpatient 3 DOA ne 5 🗆 Residence 6 🗀 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DEȘCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO ВУ 2 Accident 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To like best of my knowledge, death occurred at the ilme, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 038625 HITENAND 28 .3 2

JUNEUS GERHAPPIC CENTER

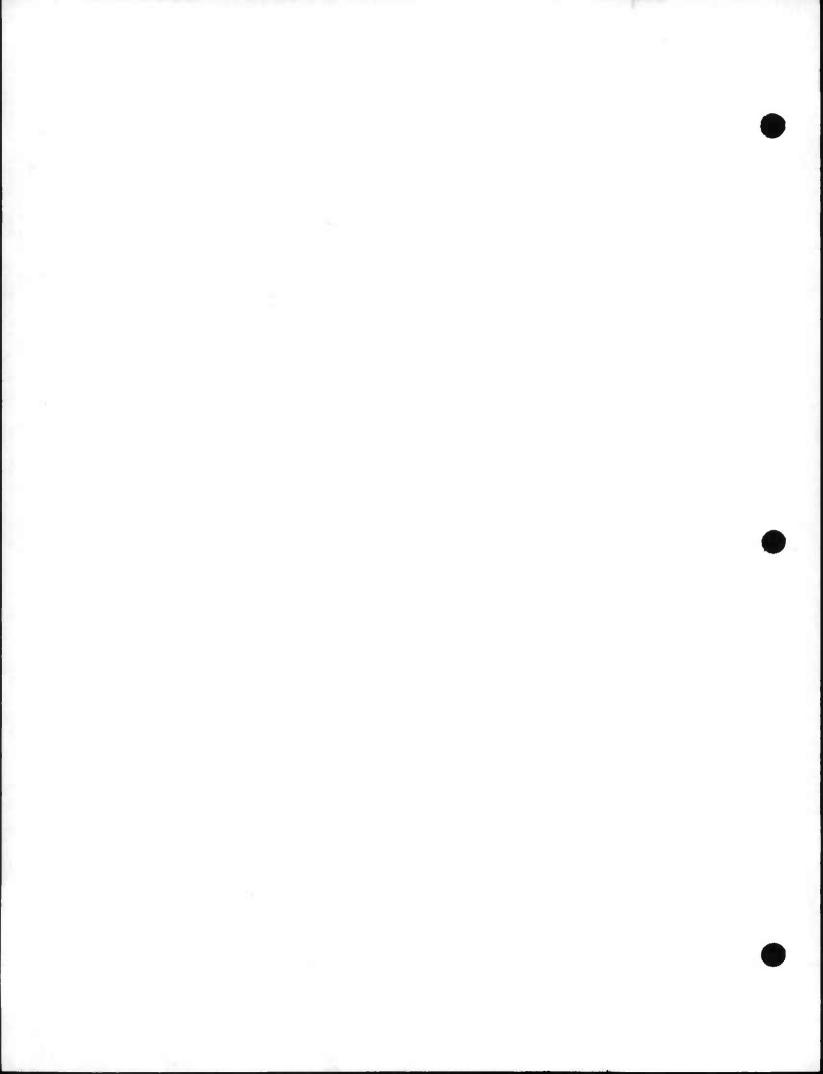
30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

HEIDI

31. DATE FILEO (MONTH, Day, Year) MAR 31 1993

AUGRBACH, Uno

32. REGISTRAR'S SIGNATURE Einder Rudally



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAL

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG. NO.

	REGISTRAR		C	ERTIF	ICAIL	· Or	DEA	П	H	EG. NO.			
	1. DECEDENT'S HAME (First, Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEATH
	AUD	REY ELI	ZABETH	HU	RST				монтн 3-1	4-93		YEAR	9:30P M
- 6	4. SOCIAL SECURITY HUMBER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER		IF UNDER	24 HRS.	7. DATE OF I			BIRTI	IPLACE (State or Foreign
	045 18 7727	1 🗆 M 2 🖵 F	69	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Da 12-2-			Count	nn onn
	9a. FACILITY NAME (If not institution, give s	street and number)			9b. CITY,	TOWN 0	R LOCATI	ON OF DE			9c. COUNT		
E .	3612 Liberty He:	i ab+c			Da	1 _ 4 -							
K	RESIDENCE OF DECEDENT	rgires			Baltimore na								
FUNERAL DIRECTOR						R LOCAT	ION						10d. INSIDE CITY LIMITS?
ā	Maryland	na		E	Balti	more	2						1 YES 2 NO
AL	10e. STREET AND HUMBER					-	. ZIP COD	E			10g. CITIZ	EN OF Y	WHAT COUNTRY?
ER.	3612 Liberty He:	ighte Ave	nua				212	15				770	7.7
S	11. MARITAL STATUS	12. WAS DECEDENT	T EVER IN U.S. AF	RMED	13. V	WAS DEC			IIC ORIGIN? (S	pecify Yes	or No.	U.S	
F	1 Never Married 2 Married	FORCES? 1	YES 2	NO	36	yes, spe	ecify Cube	ın, Mexica	n, Puerto Rica	n, etc.)			E — American Indian, k, White, atc.
B	3 Widowed 4 Divorced			10	- 1 '		2 110	opeun				Spec	Black
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. DI	ECEDENT'S	USUAL OC	CUPATIO	ON .		16b. KIN	D OF BUS	INESS/INDU	STRY	
Ξį,	Elementary/Secondary (0-12)	College (1-4 or 5+	fide.	Give kind of v a. Do NOT us	work done d se retired.)	uring mo	st of worki	ng	US 1	reder	al Go	7V 1	-
P	12 +	2											
ő	17. FATHER'S NAME (First, Middle, Last)						18. MOT	HER'S NA	ME (First, Middl	e, Maiden S	Surname)		
BE							El	izab	eth				
	19a. INFORMANT'S NAME (Type/Print)		19	96. MAILIHG	ADDRESS	(Street a			Poute Number, (alty or Town	, State, Zip (Code)	
2	Sevilla B. Carr	011		36	12 T.i	hor	+ * * * U	oiah	tsAve,	Pal+	o MD	212	15
	20a. METHOD OF DISPOSITION		20b. PLACE					CIGII	DATE		ATION - C		
	1 Burial 2 Cremation 3 Rem 4 Donation 6 Other (Specify)	oval from State	cemetery, cre						1			.,	
- 1	21. SIGNATURE OF FOMERAL SERVICE LIE	CENSEE DANS	d Wade,	n/	22. N	IAME AH	ID ADORE	SS OF FA	CHUTY				
	X) 11	11 Milas	.a wade,	DIL					St			-	Board
	with /11	Muce			65	5W.1	Ralt:	more	eSt,Ba	Lto,N	1D 21	20 1	
_4										_			
4	23. PART I. Enter the diseases, or	complications that	caused the de	aath. Do r	not antar	the mo	da of dy	ing, suci	h as cardiac	or reapir	atory arre	st,	Approximata
	snock, or naart failure.	complications that List only one cau	SO OD OBCD IID:								atory arre	st,	Approximata interval Between Onset and Death
	iMMEDIATE CAUSE (Final disease or condition	complications that List only one cau	SO OD OBCD IID:								atory arre	st,	interval Between
/	iMMEDIATE CAUSE (Final	complications that List only one cause a. DUE TO	SO OD OBCD IID:						o MA		atory arre	st,	interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that List only one cau-	SO OD OBCD IID:								atory arre	st,	interval Between
LION	iMMEDIATE CAUSE (Final disease or condition	LIST ONLY ONE CAU	SO OD OBCD IID:	SVL	42						atory arre	st,	interval Between
CATION	immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	LIST ONLY ONE CAU	TOCELL (OR AS A CONSE	SVL	42						atory arre	st,	interval Between
IFICATION	immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO	TOCELL (OR AS A CONSE	QUENCE OF	AR Pi:						atory arre	st,	interval Between
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	immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO	OR AS A CONSE	QUENCE OF	AR Pi:	C	4R	LIN.	OMA		WTOPSY		Interval Between Onset and Death UK KNOWN WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
	immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO	OR AS A CONSE	QUENCE OF	AR Pi:	C	4R	LIN.	Part I. 244	. WAS AN /	WTOPSY MED		interval Between Onest and Death UN KNOWN
EDICAL	immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO	OR AS A CONSE	QUENCE OF	AR Pi:	C	4R	LIN.	Part I. 244	. WAS AN / PERFOR	WTOPSY MED		WERE AUTOPSY FINDINGS AMAILBLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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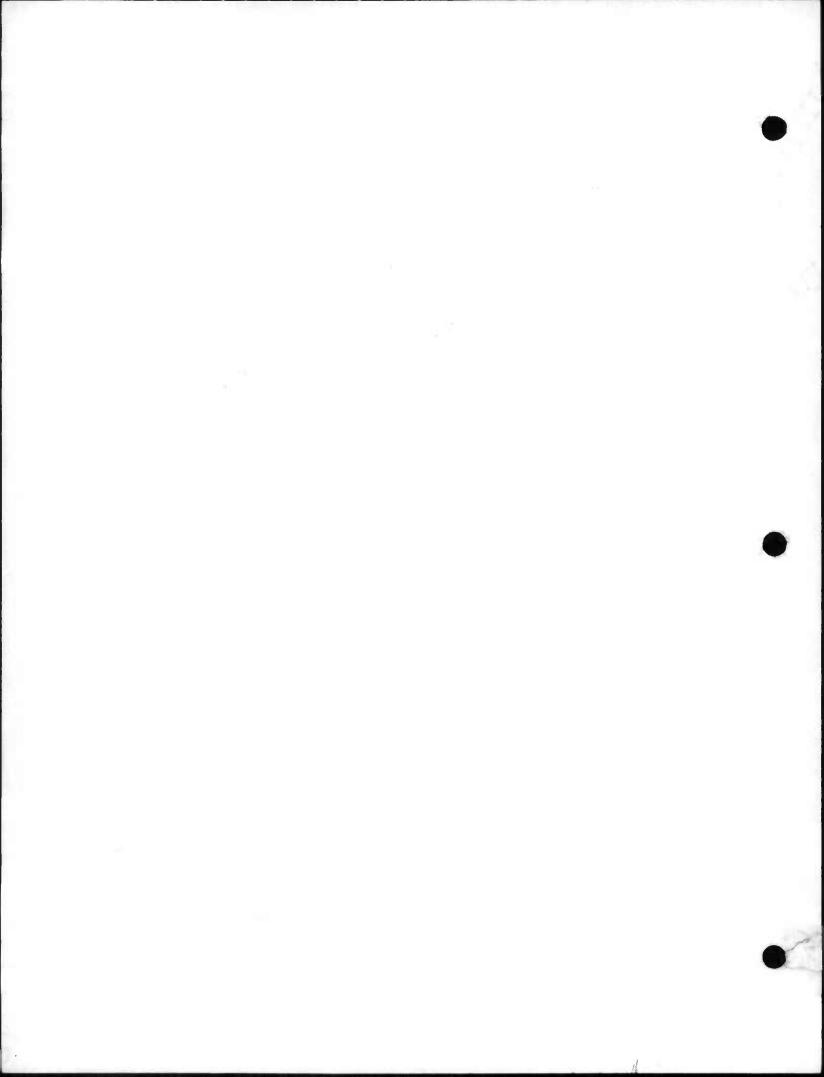
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

A ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	RECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	ne State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	m 28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSIC	TO THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death with the	MPORTANT: If Item 28 is marked,
TO THE HOSP	TO THE FUNE	be filed within	IMPORTANT

7a.n.-31. Date Filed (Moriti, Day, Your) MAR 31 1993

								93		18622
FOR STATE REGISTRAR	STATE OF MA	RYLAND C	DEPART	MENT OF	HEALTH AN	ID MEN	REG. NO			
1. DECEDENT'S NAME (First, Middle, Last)						2, D/	TE OF DEATH		3	. TIME OF DEATH
Terrell		tunt	or			MC	HTM		EAR R3	1802
4. SOCIAL SECURITY NUMBER	5. SEX 6.	1 - 1 - 1					(5			
4. SOURL SCOONTT NOWBER	1 Ø M 2 □ F	AGE (In yrs. le		IF UNDER 1 YEAR	HOURS M	(14	TE OF BIRTH onth, Day, Year)		Country)	ACE (State or Foreig
9a. FACILITY NAME (If not institution, give str	set and number)				OR LOCATION O	OF DEATH		9c. COUNTY	OF DEA	TPH .
University of M	aryland A	red (Ctr.	Balt	imore			2.3		** * * * * * * * * * * * * * * * * * *
10s. STATE 10b. COUNTY				TOWN OR LOC					1	Od. INSIDE CITY
MP Ball	Fimore		Bo	itima	re_				1	TYES 2 NO
10e. STREET AND NUMBER					IOI. ZIP CODE			10g. CITIZEN	OF WH	AT COUNTRY?
43/2 Main	Auro				WP 21	TOC				
11. MARITAL STATUS						<u> </u>				
1. Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 U IF YES, GIVE WAR	YES 2		If yes,	ECENDENT OF HI apocify Cuban, M ES 20 NO S			s or No 14.	Black, \	- American Indian, Whita, etc. Black
15. DECEDENT'S EDUC		16a. D	ECEDENT'S U	SUAL OCCUPA	TION		16b. KIND OF BU	SINESS/INDUS	TRY	
(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	, (C	Give kind of wo le. Do NOT use	ork done during retired.)	nost of working					
					_					
17. FATHER'S NAME (First, Middle, Last)	- 1				18. MOTHER	S NAME (Fir	st, Middle, Maiden	Sumame)	Į.	
Lavale Leon	Smith	1			Ki	m	Denisa	2 Hu	int	er
19a. INFORMANT'S NAME (Type/Print)			9b. MAILING /	ADDRESS (Stree	t and Number or F	iural Route N	umber, City or Tow	rn, State, Zip Co	de)	
Kim Hunter										
20a. METHOD OF DISPOSITION							- 1			2000
1 Burial 2 Cremation 3 Remo			rematory or oth				ATE 20c. LC	CATION City	or lown	n, Stata
21. SIGNATURE OF FUNERAL SERVICE LICE	Ronald	Wade.	Dir	22, NAME	AND AGORESS C	F FACILITY	Stato	Anaton	n D	hw.co.
	Al hea		3/25	100 01	E 17 D-1	1 4 2				
ancuel 15	auce				55 W.Bal					201
23 PART I. Enter the diseases, or co shock, or heart failure. L	emplications that c	aused the d	eath. Do no	ot anter the r	node of dying,	such as c	ardiac or resp	Iratory arrest	ig	Approximate
IMMEDIATE CAUSE (Final	ist only ona cause	on aach iin	la.							Onset and D
disease or condition	Extrem	00		1/1						Onset and D
resulting in death)										
	DUE TO (OI	AS A CONSE	EOUENCE OF)	: 0						
Sequentially list conditions,	DUE TO (Of	R AS A CONSE	EQUENCE OF							+
if any, leading to immediate cause. Enter UNDERLYING			,							j
CAUSE (Disease or Injury										1
that initiated events	OUE TO (OF	R AS A CONSE	EQUENCE OF)	:						-
resulting in death) LAST										
PART II. Other algnificant conditions	contributing to de	eath but not	resulting in	the underly	ng cause give	n in Part i	24a, WAS AN			VERE AUTOPSY FINDI
							PERFO			MAILABLE PRIOR TO COMPLETION OF CAUS
							1 TYES	2 100	0	F DEATH?
									1	☐ YES 2 ☐ NO
							1			
25. WAS CASE REFERRED TO MEDICAL				26.	PLACE OF DEATI	H (Check onli	(one)			
EXAMINER?	HOSPITAL:			OTHER:						
	1 Inpatient 2 E		1		ome 5 🗆 Reside					
27. MANNER OF DEATH	28a. DATE OF IN. (Month, Day,		28b. TIME INJU	OF 28c. I	NJURY AT VORK?	28d.	DESCRIBE HOW	INJURY OCCUR	ED	
1/2 Natural 5 Pending 2 Accident Investigation					YES 2 NO	0				
2 Outstda	26a. PLACE OF II	NJURY — At h	ome, farm. =	reet, factory, of	fica	281 1	OCATION (Street	and Number or	Rumi Ro	uto Number
4 Homicide 6 Could not be	building, etc	:. (Specify)					City or Town, State,		AREI FIOL	eno inuttivol,
29a. CERTIFIER			ELIKYATET							
(Check only	IAN: To the best of my									
2 MEDICAL EXAMINER	i: On the beals of axen	nination and/or	rinveatigation	, in my opinion	death occured a	it the lime, o	lata and place, or	nd due to the c	ause(a) 4	and manner as state
19b. SIGNATURE AND THE OF CERTIFIER					20- 110510-	MIMOSO		204 0477	ONE	March 6- V-
	API	44			29c. LICENSE	NUMBER		290. DATE S	SNEU (A	Month, Day, Year)
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OR	that
RECO	requires
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Ψ	The
OF VI	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2
	OR.
	HOSPITAL OR A

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3-26-93 MONTH ane HEAR POBERT HEPP 3. TIME OF OFATN Rober 305A 03 3 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 18 38 1 M 2 | F MONTHS DAYS HOURS 03-19-0 director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR timore re County General Hsp Randallstown Balto County 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore County Dundalk 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 37 Broadship Road 21222 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 NO 1 Never Married 2 K Married В 1 YES 2 NO Specify. 3 Widowed 4 Divorced 1945 White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade complete) Elementary/Secondary (0-12) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) notified at BE Ellsworth H. Olney Flora Julia Lavcox Olnev 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Broadship Rd, Baltimore, MD 21222 Geraldane Hepp e 20s. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1 🗆 Burial 2 🗔 Cremation 3 🗆 Re 4 Donation Other (Specify) examiner 22. NAME AND ADDRESS OF FACILITY tate Anatomy Board Ronald Wade, Dir filled in by the funeral 3/29/93 655W.Baltimore St, Balto, MD 21201 medical 23. PART I. Enter tife diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw 6 MMEDIATE CAUSE (Finel Onset and Death completely filled rial, cremation, c the lease or condition CONGESTIVE DUE TO (OR AS A CONSCOUENCE OF): event, t sulting in death) bunal. traumatic MEDICAL CERTIFICATION and Sequentially list conditions, DUE TOTOR AS A CONSEQUENCE OF): has been signed by the attending physician a Dept. of Health and Mental Hygiene prior to 1.23 shows any Injury, or other traums if any, leading to immediate cause. Enter UNDERLYING NEUMONIA CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO IN FARC COMPLETION OF CAUSE 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO Item 26. PLACE OF DEATH (Check only one) DIRECTOR: After this certificate hours after death with the State I tem 28 is marked, or Item OTHER: Inpetient 2 - ER/Outpetient 3 - DOA 4 🗆 No ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED 1 Natural
2 Accident 5 Pending investigation BY 1 YES 2 NO 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 M MEDICAL EXAMINER: On the basis of exami stion and/or investigation, in my opinion, deeth occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIED 29d. DATE SIGNED (Month), Day, Year)

325 93 29c. LICENSE NUMBER BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CADE OF DEATH (ITEM 27) (Type, Print) AYNOL DEVESTRE D 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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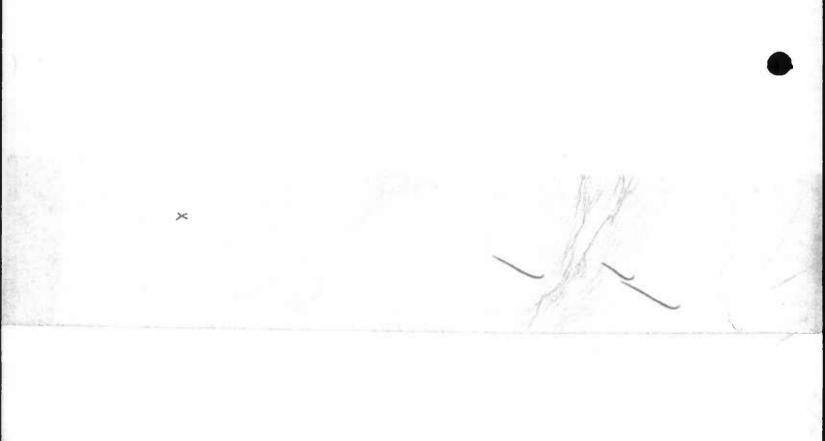
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FOR STATE REGISTRAR CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH BRADLEY M. HATHAWAY 24 1993 9:35 p 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) HOURS 1 M 2 F YRS. 298-14-9463 JAN. filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should on, or removal. 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR HOSPITAL CORPORATION BALTIMORE CITY 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY PARYLAND BALTIMORE RRY HAU 1 YES 2 1 NO FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21236 U.S.A ours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried 8 1 YES 2 NO Specify: 3 Wildowed 4 Divorced الحدر COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 YRS ZYRS 203 PACH. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surneme) notified at BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 FAMILY ABOVS AS SAME Pe 20a. METHOD OF DISPOSITION
1 St. Burlel 2 Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of 3.27 20c. LOCATION - City or Town, State must PARKVIL 4 Donation 5 Other (Specify) MARYLAND ARKWOOD SMEISPY examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY EXPORTES 8800 HARFORD medicai 23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. Liet only one cause on each line. Approximata 6 Interval Between **IMMEDIATE CAUSE (Final Onset and Death** completely filled rial, cremation, other traumatic event, the disease or condition MYSEAMIA WFARCEMON AZUTE resulting in death) executed within OUE TO (OR AS A CONSEQUENCE OF): THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and comfiled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to buriat, correctory ANSTERM CERTIFICATION Sequentielly list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) thet initiated evente resulting in deeth) LAST 6 in ury, PART II. Other algoriticent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO 23 shows any COMPLETION OF CAUSE 1 - YES 200 NO DF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? or item 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 🗌 YES 2 🖳 4 - Nursing H e 5 Residence 6 Other (Specify) 27. MANNER OF DEATH (Month, Day, Year) item 28 is marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCUREO Natural 5 Pending Investigation м 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29e. CERTIFIER

(Chack only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(e) end menner as stated. TO THE FUNERAL De filed within 72 hi 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, end due to the ceuse(a) and menner as stated. 295 SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNEO (Month, Day, 29c. LICENSE NUMBER BE 36974 31 24/3 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAMO O.NYAWJOM ~ 100 N RRUAD WAY garinons my 21231 31. DATE FILED (Month, Day, Year) 32, REGISTRAR'S SIGNATURE 1993 3

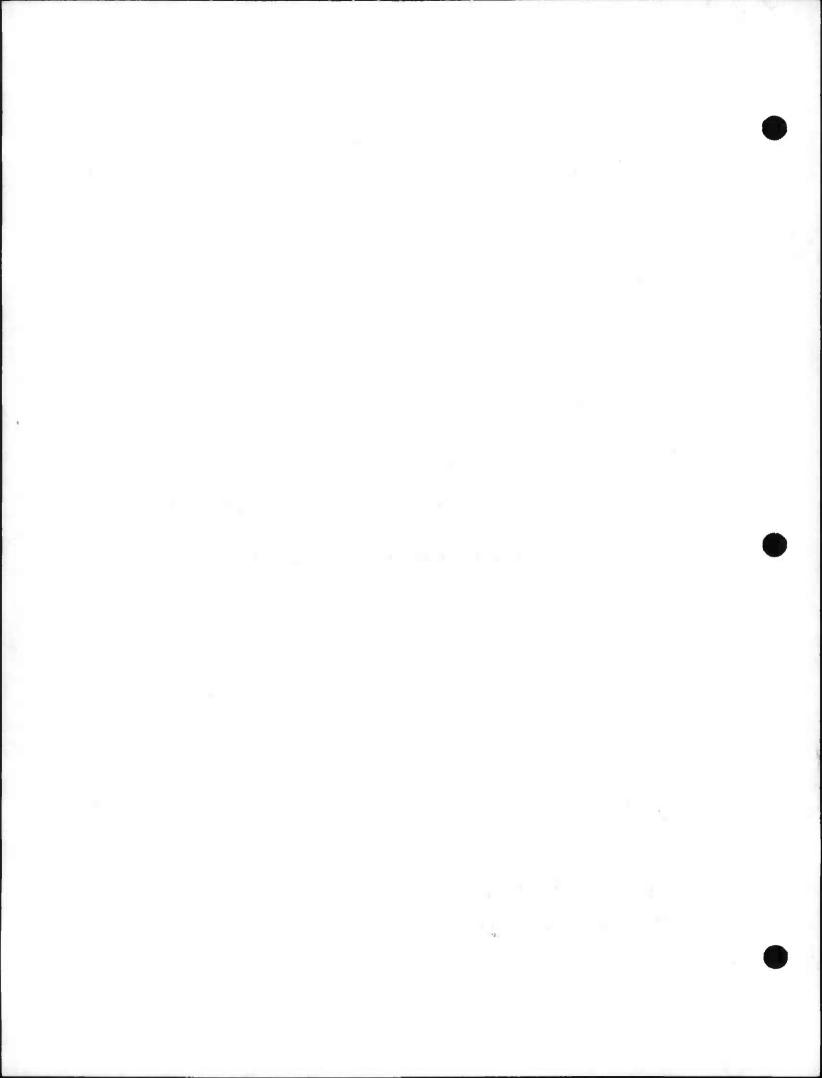




DIVISION OF VITAL RECORDS, P.O. BOX 68760,

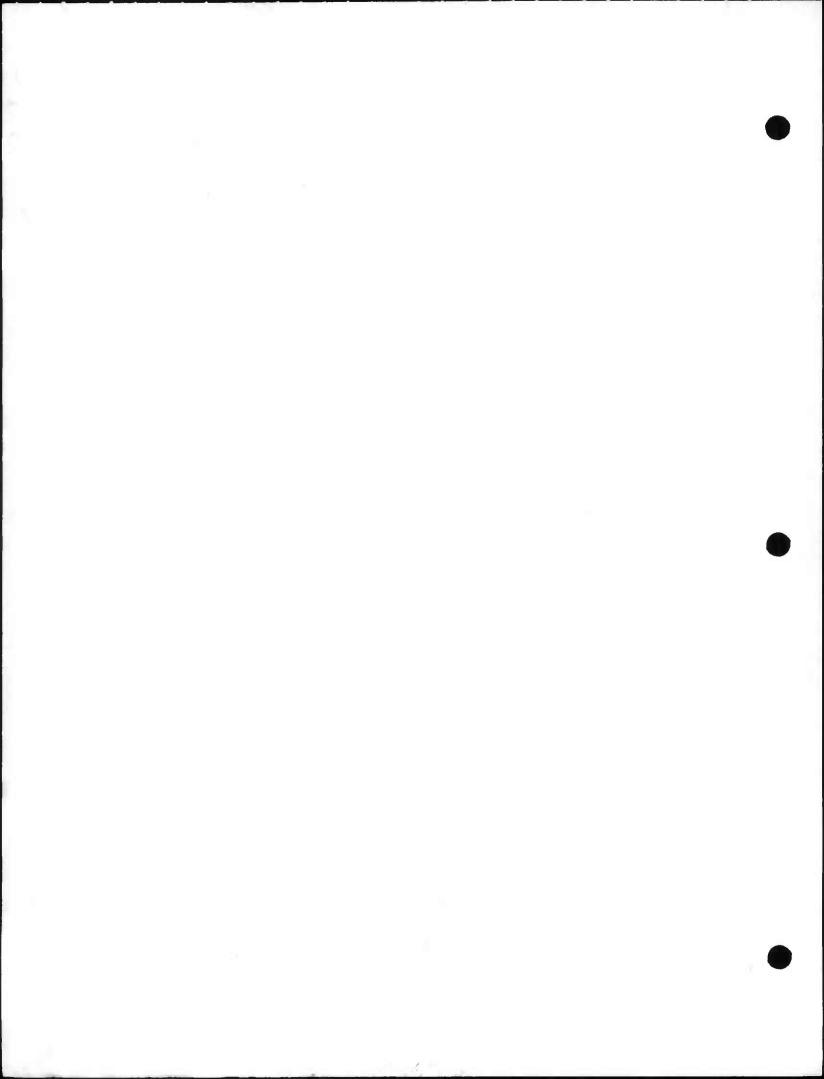
CIPOR 1 - STATE

	REGISTRAR		CERTI	FICA	re of	DEATH		REG. NO						
	1. DECEDENT'S NAME (First, Middle, Last)									2. DATE OF DEATH 3. TIME OF D				
	CLIFTON	LEROY	HE	HEBRON			03 26 1			12:20	Рм			
			(in yrs. last birthde		DER 1 YEAR	IF UNDER 24 H		OF BIRTH	, 1.		IPLACE (State or For			
	216-34-2574	M 2 □ F	55 ^{YRS}		_	HOURS MI	N. (Mon	th, Day, Year)		Count	ry)	agn		
	9a. FACILITY NAME (If not institution, give street		25	-			Dec	26	1937		ryland			
m	The Property Name (if not institution, give street	t and number)		9b. C	ITY, TOWN C	OR LOCATION O	F DEATH		9c. COU	INTY OF D	DEATH			
СТОВ	135 WESLEY AVENUE #2 CATONSVILLE BALTIMORE													
FUNERAL DIRECT	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		100.0	TV TOW	N OR LOCAT	TION.								
			100.0							10d. INSIDE CITY LIMITS?				
	Maryland		Catonsville							1 X YES 2 [NO			
	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT CO													
	135 Wesley Avenue	21228		US	SA									
		2. WAS DECEDENT EVER I							or No-	14. RACE — American Indian, Black, White, atc.				
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D						Rican, etc.)		Specify:				
											Black			
	15. DECEDENT'S EDUCATI (Specify only highest grade con	ION noleted)	18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working					16b. KIND OF BUSINESS/INDUS						
		College (1-4 or 5 +)	life. Do NOT	use retired	1.)	at or working								
<u>م</u> و	High School		M	ursi	na Se	rvice		Spring	r Gro	ve H	Ospital			
once. COMPLET	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S	S NAME (First,	Middle, Maiden						
ш	Francis Edward Heb	ron				Mild	red Ma	tthews	2					
8	19a. INFORMANT'S NAME (Type/Print)	LOIT	19b. MAILU	NG ADOR	ESS (Street a	nd Number or R				o Code)				
5	Carol Borden										.00			
9	20g: METHOD OF DISPOSITION	100				venue		imore,		212				
nest	1 🗗 Burial 2 🗆 Cremation 3 🗆 Removal	from State cen	PLACE AND DAT	other plea	al			ATE 20c. LOCATION City or Town, Stata						
E	4 Donation 5 Other (Specify)		oodlawn	Cem	etery		3/3	1 Ba1	Ltimo	re,	14D			
Ē	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY NITHER FUNDER TO										nc.			
exa	Herbert E. Trutter 2501 Gwynns Falls Parkway Baltimore, Maryland 21216													
or other traumatic event, the medical examiner must be notified at once. ERTIFICATION TO BE COM	23. PART I. Enter the diseesea, or com	pilicetions thet cause	d the deeth. Do							root	I Annovimo	4.0		
9	shock, or heert failure. List	t only one cause on a	ech line.			do or dying,	aucii da cui	diec or respi	ratory ar	reet,	Approxime interval Be			
2	iMMEDIATE CAUSE (Finei disease or condition	14				b					Onset and	Death		
<u>.</u>	resulting in death)	MULTIPLE				Moun	102							
200		DUE TO (OR AS A	CONSEQUENCE	OF):										
S Z	Securetally list conditions b.										ļ			
ERTIFICATION	Sequentially liet conditions, if any, leading to immediata DUE TO (OR AS A CONSEQUENCE OF):													
S	CAUSE (Disease or injury													
	that initiated events OUE TO (OR AS A CONSEQUENCE OF):													
2 E	resulting in death) LAST													
DICAL CE	DART II OAL													
	PART ii. Other eignificant conditions of	ontributing to death b	ut not resulting	g in the	underlying	g ceuse giver	in Part i.	24a. WAS AN PERFOR		24b	WERE AUTOPSY FIN AMAILABLE PRIOR T			
	1 YES 2 NO										COMPLETION OF CA			
ME										1 YES 2 N	0			
E -														
is marked, or item 23 shows D BY PHYSICIAN: MEI	25. WAS CASE REFERRED TO MEDICAL				26. PL	ACE OF OEATH	(Check only o	ne)						
SIC		OSPITAL: Inpetiant 2 ER/Outp	atient 3 DOA	ОТН		a M. Whoolder		- (C						
<u> </u>	27. MANNER OF CEATH	28e. DATE OF INJURY		ME OF	28c. INJ	e KARasider		SCRIBE HOW I	N IIIDY OO	CHRED				
<u>a</u>	1 Natural 5 Pending	(Month, Day, Year)	1	NJURY	wo	RK?								
B B	2 Accident Investigation	03/26/19				rES 2 NO		SUBJECT BEATEN						
E C	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Spec	RY — At home, ferm, street, factory, offica					19 3 or Bresser and Number of Vernous Pumble 2						
~ ⊢	- El monnos garattimad		R_	HO	ME		CAT	ONSVI	LLE.	, MA	RYLAND			
O BE COMPLE	29a. CERTIFIER 1 CERTIFYING PHYSICIAN	N: To the best of my know	ledge, death occu	rred at the	e Ilme, data	and place, and	dua to the ca	use(a) and mar	nor se ste	ted.	21228			
	CENTIFIEN 1 CETTIFIEN 2 CETTIFING PHYSICIAN: To the best of my knowledge, death occurred at the ilme, data and place, and due to the cause(a) and manner as stated. 21228 (Check only one) 2 M MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the ilme, data and place, and due to the cause(a) and manner as stated.													
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	200 CANADATION AND THE OF OFFICER													
B			29c, LICENSE NUMBER					29d. DATE SIGNED (Month, Day, Year)						
2	wegue me			M.E.		03/27/1993								
1-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
	1. C CHREENALL.	ORISTUM 1	11 Pen	n s	tree	t. Ba	ltimo	re. M	larv'	land	2120	1		
	31. DATE THE DAY MONTH, Day You	I more armidizar	malant men											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 12 hours after death with the State Dept, of Health and Mental Hypiere prior to burial, certain, or removal.

	REGISTRAR				CERTIF	ICALE	OF	DEATH		R	EG. NO							
į.	1. DECEDENT'S HAME (First, Middle, Last) John Jacob Heinz								1	2. DATE OF DEATH MONTH 28, 1993 YEAR 250 N								
					rs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.					7. DATE OF BIRTH			6 4, 1					
	219-18-1670		1 □XM 2 □ F	79		MONTHS	DAYS	HOURS ME	RS. 7	05/09	13		Count	HPLACE (State or Foreign y)				
	9a. FACILITY NAME (If not institution, give street and number)					9b. CITY,	OR LOCATION C											
5	4409 Leeds Avenue					Arbu				200	imor							
I K		RESIDENCE OF DECEDENT										Part	TUOL	6				
DIRECTOR	10a. STATE 10	Balti	more		10c. CIT	Y, TOWN OF Balt	LOCAT	TION			-			10d. INSIDE CITY LIMITS?				
						Darc	16					1 TES 2 NO						
FUNERAL	100. STREET AND NUMBER 4409 Leeds Avenue						101	10f. Zip CODE 21229					10g. CITIZEN OF WHAT COUNTRY? USA					
اچ	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. A 1 Never Married 2 X Married FORCES? 1 ☐ YES 2 ∑					ARMED 13. WAS DECEHOENT OF HISP						or No-	14. RAC	E - American Indian,				
BY F	1 Never Married 2 X Married FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES				NO If yes, specify Cuban, Mexi									k, White, etc.				
	15. DECEDE	. DECEDENT'S	DECEDENT'S USUAL OCCUPATION					D OF BUS	SINESS/IH	111111	Ce .							
E	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				(Give kind of work done during most of working life. Do NOT use retired.)													
COMPLETED					arber	self			f									
Ö	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA					AME (First, Middle, Maiden Surname)							
BE		Joseph Heinz					Eva Raab											
0		19a. INFORMANT'S NAME (Type/Print)					19b. MAILING ADDRESS (Street and Number or Rural R						Route Number, City or Town, State, Zip Code)					
	Mrs. Irene H				4409	4409 Leeds Avenue					ore		Md 21229					
	20a, METHOD OF DISPOSITION 1 Deuriel 2 Cremation 3 Removal from State Competery, c					OF DISPOSIT	me of		OATÉ			- City or Town, Stata						
	4 □ Donation 5 □ Other (Sp 21. SIGNATURE OF) FUNERAL, SI	-	user -	New	Cathe	drai	Cem	etery		-7 1	В	alti	more	, Maryland				
	22. HAME AND ADDRESS OF FACILITAMBrose Funeral Home 1328 Sulphur Spring Road, Arbutus, Md																	
	25. PART I. Enter the dise	eses, or co	mplicatione the	ceused the	death. Dp r	not enter t	he mo	de of dying.	such s	s cerdiec	or reepi	ratory er	rnet.	Approximete				
	shock, or heer IMMEDIATE CAUSE (Final	t feliure. Li	st only one ceu	se on eech	line.									intervai Between				
	disesse or condition		A	2	-1	ald	1	luel						Caralla				
1	resulting in death)	a.	OUE NO.	OR AS A CON	SEQUENCE OF	2:	OFF	10	u	che che	, ly	em	3	secaray				
Z	Tileracle de Cartinagala Neces																	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING																	
윤	CAUSE (Disease or injury	С.	OUE TO	OR AS A CON	ISEQUENCE OF	D.			_									
튒	that initiated events resulting in death) LAST			(011 70 71 001	ISCOULINGE OF									i				
G		d.												1				
AL	PART ii. Other eignificant	ot resulting i	in the und	erlying	ceuse giver	in Pa	Part i. 24a. WAS AN AUTOPSY PERFORMED?			24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO							
EDICAL							1 _ YES 2 NO				COMPLETION OF CAUSE OF DEATH?							
WE I											1 YE\$ 2 HO							
PHYSICIAN	25. WAS CASE REFERRED TO M EXAMINER?		HOSPITAL:					ACE OF DEATH	(Check	only one)								
YSI	1 TYES 2 NO		☐ Inpatient 2 ☐	ER/Outpatien	t 3 🗆 DOA	OTHER:		5 Rasider	nca e	Other (Spe	cify)							
F	27. MAHHER OF OEATH	Mar.	20a. DATE OF (Month, Da		28b. TIM	E OF 2	Bc. INJE		28	Bd. DESCRIB	E HOW II	NJURY OC	CURED	11				
BY	1 Hatural 5 Pending						M 1 TES 2 HO											
	3 Suicide e Could not be determined 28e. PLACE OF IHJURY — At home, farm, s building, etc. (Specify)						reel, 1sctory, offica 281. LOCATIOH (Street and Number or Rural Route Number, City or Town, State)						Route Number,					
COMPLETED	DO CONTINUE V																	
MP	(Check only 1) CERTIFYING PHYSICIAH: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.																	
8	one) 2 MEDICAL EXAMIHER: On the basis of examination and/or investigation, in my opinion, dasth occured at the time, data and place, and due to the cause(a) and manner as stated.																	
BE	296. SIGNATURE AND TITLE AS CENTURER 29d. DATE SIGNED (Majort, Day, Year)																	
2											173							
	Herbert 1	T. L	ZVIC-T	as 9	5 4	604 Z	East Drie Baltomore, Md 21227											
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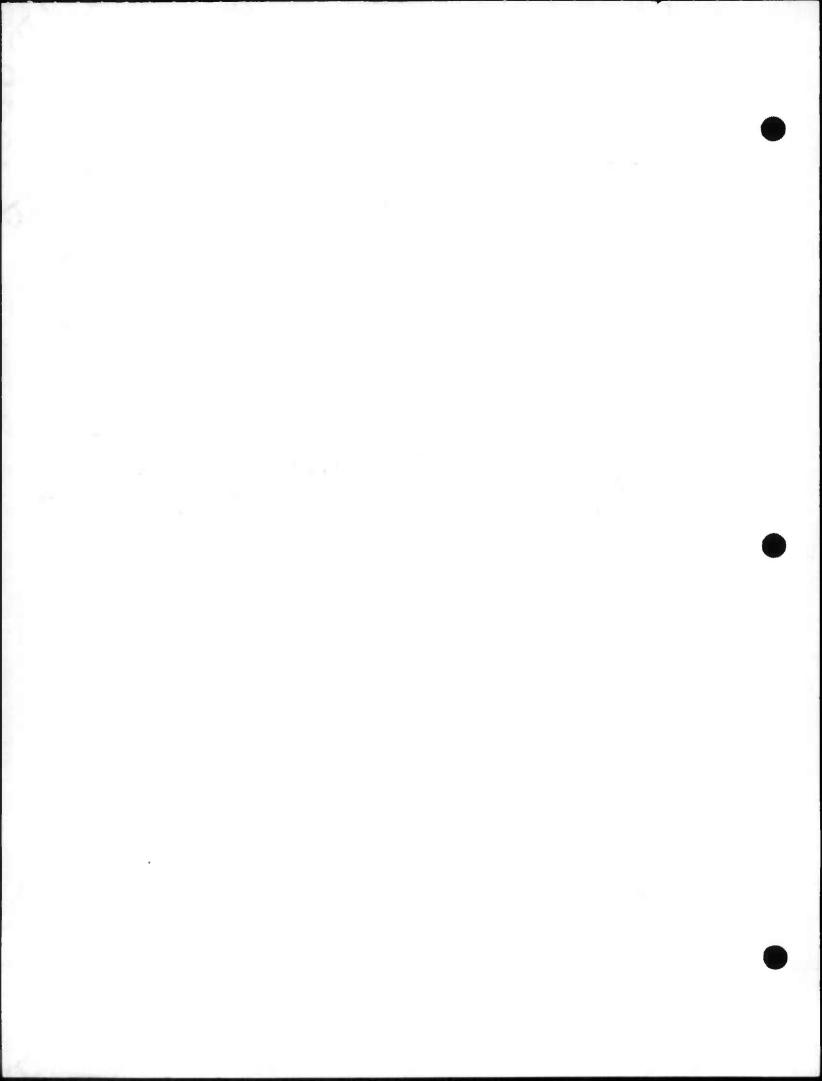
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by me hopeful or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be offered with the State Dept. of Health and Mental Hygiene prior to burial. cremation. or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any inline, or other transmant.

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	AAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be only as the buria	72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	16 flows 28 is marked as flows and injury as other transmission areas the marked avantage and the market as and
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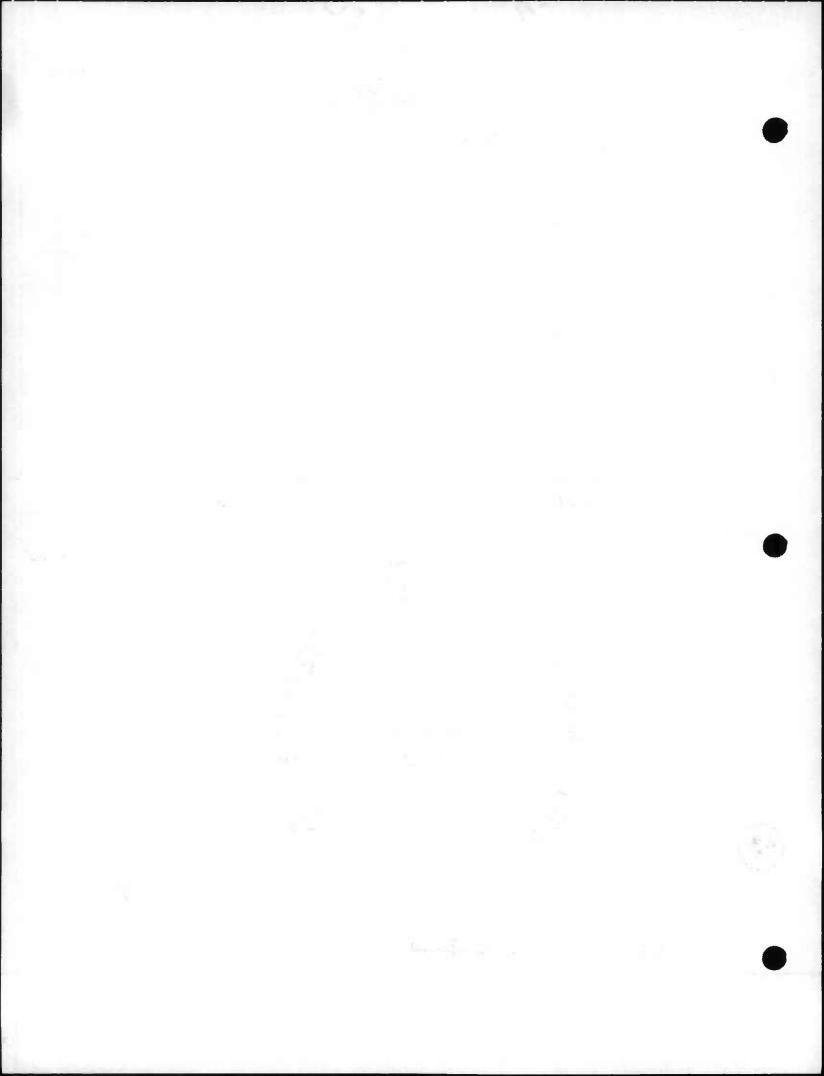
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	FOR 1 - STATE	STATE OF N	IARYLAND	/ DEPAR	TMENT OF	HEALTH	AND M			E		
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest)			SERTIF	CATE C	PF DEAT	Н	2. DATE OF	REG. NO.			
	CHRISTINE			НАН	J			MONTH 3	27 th	199	YEAR 3	10:20 Am
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UNDER 1 YEA	AR IF UNDER	24 HRS.	7. DATE OF	BIRTH	1.77		ACE (State or Foreign
	218-44-8611	1 _3 M 2 🂢 F	88	YRS.	MONTHS DAY	8 HOURS	MIN.	(Month, D	ay, Year) -190	1	Country)	many
	9a. FACILITY NAME (If not institution, give s	street and number)			9b. CITY, TOV	N OR LOCATIO	ON OF DEA		170	_	TY OF DEA	
DIRECTOR	FRANCIS SCOTT F	KEY MEDI	CAL C	ENTE	R BA	ALTIMO	ORE	CITY				
E C	10a. STATE 10b. COUNT	Y		10c. CIT	, TOWN OR LO	CATION					10	d. INSIDE CITY
듬	Maryland	Baltimo	re				Edge	тоно				LIMITS?
\¥	10e. STREET AND NUMBER				I	10f. ZIP CODE				10g. CITIZ	EN OF WHA	AT COUNTRY?
FUNERAL	7423 North Poi						212			Uni	ted S	States
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	YES 2		If yea	DECENDENT O	n, Maxican,	C ORIGIN? (S Puarto Rica	Specify Yearn, atc.)	or No-	14. RACE — Black, V	American Indian, White, atc.
BY	3 € Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1 🗆 '	YES 2 KNO	Specify:			- 1	Specify:	White
ED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a.	DECEDENT'S	USUAL OCCUP	ATION		16b. Kil	ND OF BUS	INESS/INDU	JSTRY	white
9	Elementary/Secondary (0-12)	College (1-4 or 5+)		ork done during e retired.)	most or workin	v					
COMPLETED	7th Grade 17. FATHER'S NAME (First, Middle, Last)			Gro	cer					Empl	oued	
ECC	Alfice Weber							E (First, Midd		Sumame)		
00	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (Stre			ine G.		. State. Zip	Code)	
2	Martin Hahn			7423	North	Point	Road	d. Ed	a omo t	10 M	าหนใด	nd 21219
	20s. METHOD OF DISPOSITION 1 1 Buriel 2 Cremation 3 Ram	oval from Stata	20b. PLAC									
200. LOCATION — CIE Surfal 2 Cremation 3 Ramoval from Stata 200. LOCATION — CIE A Donation 5 Other (Specify)						Mar	yland					
	Harman Service Co	7) 0										lk. Inc.
	Ossega 2	Kero			79	22 Wish	0 A111	ONLID	Dunc	lach	MD	21222
23. PART i. Enter the disease, or complications that caused the death. Do not anter the mode of shock, or heart fallure. List only one cause on each line.						moda of dyi	ng, such	aa cardiac	or reapi	ratory arre	at,	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition Arteriosclerotic Ca							1	Dies			Onset and Death
	a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):											
Z N	Sequentially list conditions.											
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO	OR AS A CONS	SEOUENCE OF):							
FIC	CAUSE (Disease or injury that initiated events	c	OR AS A CONS	SEOUENCE OF):							1
ITI	resulting in death) LAST	d.										!
	PART II. Other algorificant condition	a contributing to	death but no	t resulting I	s the underly	dog course o	dues le D		- 1100 000			
MEDICAL			addit but 110	t rasulting i	tha diden	ying cause g	iven in Pa		PERFOR	MED?	AV	ERE AUTOPSY FINDINGS AILABLE PRIOR TO DMPLETION OF CAUSE
밀								- 1	YES 2	[X NO	OF	DEATH?
ž.								- 3	thqu	MAY	''	□ YES 2 □MO
25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)						. PLACE OF DE	EATH (Checi	k only one)				
ᇙ	EXAMINER?	EXAMINER? 1 PES 2 NO HOSPITAL: 1 Inpetient 2 SER/Outpetlant 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)						Other (S	pecify)			
YSICI	EXAMINER?		ER/Outpatlant	3 LI DOA	26b. TIME OF 26c. INJURY AT							
PHYSICIAN:	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH		INJURY	26b. TIMI	OF 26c.	INJURY AT WORK?		28d. DESCRI	BE HOW IN	JURY OCCI	JRED	
В	EXAMINER? t	26a. DATE OF (Month, Da	INJURY y, Year)	26b. TIMI	OF 26c. JRY t	INJURY AT WORK?	NO					
В	EXAMINER? t VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	1 Inpatient 2 1 26a. DATE OF (Month, Da	INJURY y, Year)	26b. TIMI	OF 26c. JRY t	INJURY AT WORK?	NO	26f. LOCATIO				e Number,
В	EXAMINER? t	1 Inpetient 2 State of (Month, Da 26s. PLACE Of building, o	NJURY y. Year) INJURY — At itc. (Specify)	26b. TIMI INJI home, farm, s	OF 28c. JRY M t [treet, factory, o	INJURY AT WORK? YES 2 ffice] NO 2	26f. LOCATIC City or R	ON (Street a own, State)	nd Number c	or Rurel Rout	e Number,
В	EXAMINER? t	1 Inpetient 2 To 26s. DATE OF (Month, Da 26s. PLACE Of building, of CIAN: To the best of a	NJURY y, Year) FINJURY — At trc. (Specify) my knowledge,	26b. TIMI INJI home, farm, s	M t [treet, factory, o	INJURY AT WORK? YES 2 Iffice	NO 2	26f. LOCATIO City or R	ON (Street a own, State)	nd Number o	or Rural Rout	
E COMPLETED BY	EXAMINER? 1 TYES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be detarmined 29a. CERTIFIER (Check only)	1 Inpatient 2 Size 28s. DATE OF (Month, Da 28s. PLACE OF building, of the best of a R: On the basis of axe	NJURY y, Year) FINJURY — At trc. (Specify) my knowledge,	26b. TIMI INJI home, farm, s	M t [treet, factory, o	INJURY AT WORK? YES 2 Iffice Interest and place, n, death occurrent	NO 2	26f. LOCATIC City or R o the cause(i	ON (Street a own, State)	nd Number of	or Aurel Rout d. cause(a) ar	
BE COMPLETED BY	EXAMINER? 1 TYES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER	1 Inpetient 2 S 26s. DATE OF (Month, Da 26s. PLACE OF building, of the basis of axis.)	INJURY y, Year) INJURY — At the (Specify) my knowledge, emination and/s	26b. TiMi INJI home, farm, a death occurre or investigation	OF 28c. PRY M t [treet, factory, o d at the time, d t, in my opinior	INJURY AT WORK? YES 2 Iffice Interest and place, n, death occurrent	NO 2 and due to due to the tire	o the cause(i	ON (Street a own, State)	nd Number of	d. Cause(a) ar	od manner sa stated.
E COMPLETED BY	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	1 Inpetient 2 S 26s. DATE OF (Month, Da 26s. PLACE OF building, of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of axis of the basis of the b	NJURY y, Year) FINJURY — At rec. (Specify) my knowledge, smination and/	26b. TiMi INJI home, farm, s death occurre or investigation	E OF 28c. M t [treet, factory, o d at the time, d n, in my opinion	INJURY AT WORK? YES 2 Hitea Hitea and place, 1, death occurre 29c. LICE	and due to ed at the tir	o the cause(inne, data and	DN (Street a bwn, State) s) and manification, and manification, and manification.	nd Number of the state of due to the 29d. DATE	d. cause(s) ar	od manner as stated. onth, Day, Year) 7 1993
BE COMPLETED BY	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	1 Inpetient 2 S 26s. DATE OF (Month, Da 26s. PLACE OF building, of the basis of axis.)	INJURY y, Year) FINJURY — At tet. (Specify) my knowledge, smination and/a	26b. TiMinJi home, farm, a death occurre or investigation TEM 27) (Type, 1. Per	OF 28c. PRY M t [treet, factory, o d at the time, d t, in my opinior	INJURY AT WORK? YES 2 Hitea Hitea and place, 1, death occurre 29c. LICE	and due to ed at the tir	o the cause(inne, data and	DN (Street a bwn, State) s) and manification, and manification, and manification.	nd Number of the state of due to the 29d. DATE	d. cause(s) ar	od manner as stated. onth, Day, Year) 7 1993



BALTIMORE, MARYLAND 21215-0020

(ISION OF VITAL RECORDS, P.O. BOX 68760,

	7 C 7 1 1 Betty	Ann Lee H	Hawkins	2. DATE OF DEATH DAY	3. TIME OF DEATH					
	DOIL THOURING	7		MARCH 29,	1993 12:53A	M				
	104006	MONTH	DER 1 YEAR IF UNDER 24 HRS. IS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)					
	213-34-2546	55 YRS.		02-05-38	Maryland					
m	9a. FACILITY NAME (If not institution, give street and number)	1	ITY, TOWN OR LOCATION OF E		9c. COUNTY OF DEATH					
DIRECTOR	THE JOHNS HOPKINS HOSPITAL	B	ALTIMORE CITY	<u> </u>	34.5 (34.0)					
EC	10a. STATE 10b. COUNTY	10c. CITY, TOW	N OR LOCATION	-	10d, INSIDE CITY					
H	MARYLAND NONE			ORE CITY	LIMITS?					
	104. STREET AND NUMBER		101. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	_				
FUNERAL	1521 N. MILTON AVENUE		21213	1						
N N	11 MARITAL STATUS	N U.S. ARMED	13. WAS DECENDENT OF HISPA		United States					
	1 Never Married 2 Married FORCES? 1 YES	2 2 80	If yes, specify Cuben, Mexic 1 ☐ YES 2 ☐ NO Speci	an, Puerto Rican, etc.)	r No— 14. RACE — American Indian, Bleck, Whita, atc. Specify:					
8	3 Widowed 4 Divorced		The Tarket		AFRICAN AMERICA	A N				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USUAL	OCCUPATION ne during most of working	16b. KIND OF BUSIN		751				
19	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use retired	d.)							
MP	llth grade none	DIALASYS	TECHNICIA	N FRANC	IS SCOTT KEY					
18	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S N.	AME (First, Middle, Maiden Su						
BE	LOUIS DAVIS		MART	HA HUDSON						
0	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRE	ESS (Street and Number or Rural	Route Number, City or Town,	State, Zip Code)					
1-1	TWILA GATTIS	1521 n.	Milton Av	enue Balto	o.Md. 21213					
	1 Durial 2 Cremation 3 Removal from State cent	D. PLACE AND DATE OF DISP	POSITION (Name of	DATE 20c. LOCA	NTION — City or Town, Stata					
	4 Donation 5 Dother (Specify)	GREEN MOUN	NT CREMATOR		CIMORE, MARYLAN	ID				
	21. SIGNAPONE OF FUNERAL SERVICE VICTORISEE	0 '	22. NAME AND ADDRESS OF F	ACILITY						
	Lalum D. Acrus	Dist.	CATAIN R.	SCRUGGS FU	UNERAL HOME BALTO MD 2121	-				
	23. PART i. Enter the diseases, or complications that caused	the death. Do not an	tar the moda of dying, sur	ch as cardiac or reapira	RAITO MD 2121	4				
	ahock, or heart failure. List only one cause on a IMMEDIATE CAUSE (Final	ach lina.	W 1000 1000 1000 1000 1000 1000 1000 10		intarvai Betwe					
		In. SOFIL	(PULMONA	LA EDEMA)	2 Hours	2.0				
	DUE TO (OR AS A	A CONSCOUENCE OF):			0/10	J				
Z	End St.	Sequentially list conditions and Stage Reval DEAD STAGE RENAL DISEASE)								
임	If any, leading to immediate	ONSEQUENCE OF):								
2	cause. Enter UNDERLYING CAUSE (Disease or injury									
H	that initiated events resulting in death) LAST	A CONSEQUENCE OF):								
CERTIFICATION	d									
	PART ii. Other aignificant conditions contributing to death b	out not resulting in the	underlying cause given in	Part i. 24a. WAS AN AL		GS				
EDICAL			No. of the same of	PERFORM	ED? AVAILABLE PRIOR TO COMPLETION OF CAUSE					
回				1 🗆 YES 2	OF DEATH?					
Σ :					1 TYES 2 NO					
A	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (C	heck only one)		_				
Sic	EXAMINER? 1 Of YES 2 NO NO HOSPITAL: 1 Inpetient 2 OF RYOUTE	patient 3 DOA 4 D								
PHYSICIAN	27. MANNER OF DEATH 28a. DATE OF INJURY	28b. TIME OF	28c. INJURY AT	28d. DESCRIBE HOW INJ	URY OCCURED					
	1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation	INJURY	WORK? 1 YES 2 NO							
В В	3 Suicide 28e. PLACE OF INJURY	At home, farm, atreet, f	lactory, office	281. LOCATION (Street and	d Number or Rural Route Number,					
3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)										
			valenta in Califer Vision	to the causa(a) and menny	as as stated					
LET	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my know	lades death occurred at the	28a. CERTIFFIER 1 CERTIFFIER 1 CERTIFFIER PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, and due to the cause(a) and (Check only one) 2 MEDICAL EXAMINER: On the beat of examination end/or investigation, in my opinion, death occurred at the time, date and place							
MPLET	(Check only 1 K CERTIFYING PHYSICIAN: To the beat of my know				due to the cause(a) and menner as stated					
COMPLETED	(Check only 1 CERTIFYING PHYSICIAN: To the beat of my know one) 2 MEDICAL EXAMINER: On the beat of axamination		ny opinion, death occured at the	e time, data and place, and o		_				
BE COMPLET	(Check only 1 CERTIFYING PHYSICIAN: To the best of my know one) 2 MEDICAL EXAMINER: On the best of axamination 29b, SIGNATURE AND TITLE OF CERTIFIER		y opinion, death occured at the	e time, data and place, and d	due to the cause(a) and menner as stated 29d. DATE SIGNED (Month, Day, Year)					
u I	(Check only 1 C CERTIFFING PHYSICIAN: To the best of my know one) 2 MEDICAL EXAMINER: On the best of axamination 29b, SIGNATURE AND TITLE OF CERTIFIER WILL A. USAM.	n end/or investigation, in m	ny opinion, death occured at the	e time, data and place, and d						
BE	(Check only 1 C CERTIFFING PHYSICIAN: To the best of my know one) 2 MEDICAL EXAMINER: On the best of axamination 296, SIGNATURE AND TITLE OF CERTIFIER 38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	en end/or investigation, in m	y opinion, death occured at the	e time, data and place, and d						
BE	(Check only 1 C CERTIFFING PHYSICIAN: To the best of my know one) 2 MEDICAL EXAMINER: On the best of axamination 29b, SIGNATURE AND TITLE OF CERTIFIER WILL A. USAM.	en end/or investigation, in m ATH (ITEM 27) (Type, Print)	y opinion, death occured at the	e time, data and place, and d						



hours after death. Page 6 may be retained by the hospital or attending physician. **BALTIMORE, MARYLAND 21215-0020**

burial-transit permit. Pages 1, 2, 3 should

detached for use as the

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

funeral director, page 5 should be been signed by the attending physician and completely filled in by the nt. of Health and Mental Hygiene prior to burial, cremation, or removal. DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within has be this certificate to with the State After death DIRECTOR: / FUNERAL (HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: If

BE 2 296. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (Month, Day, Year) MAR 3 1 1993

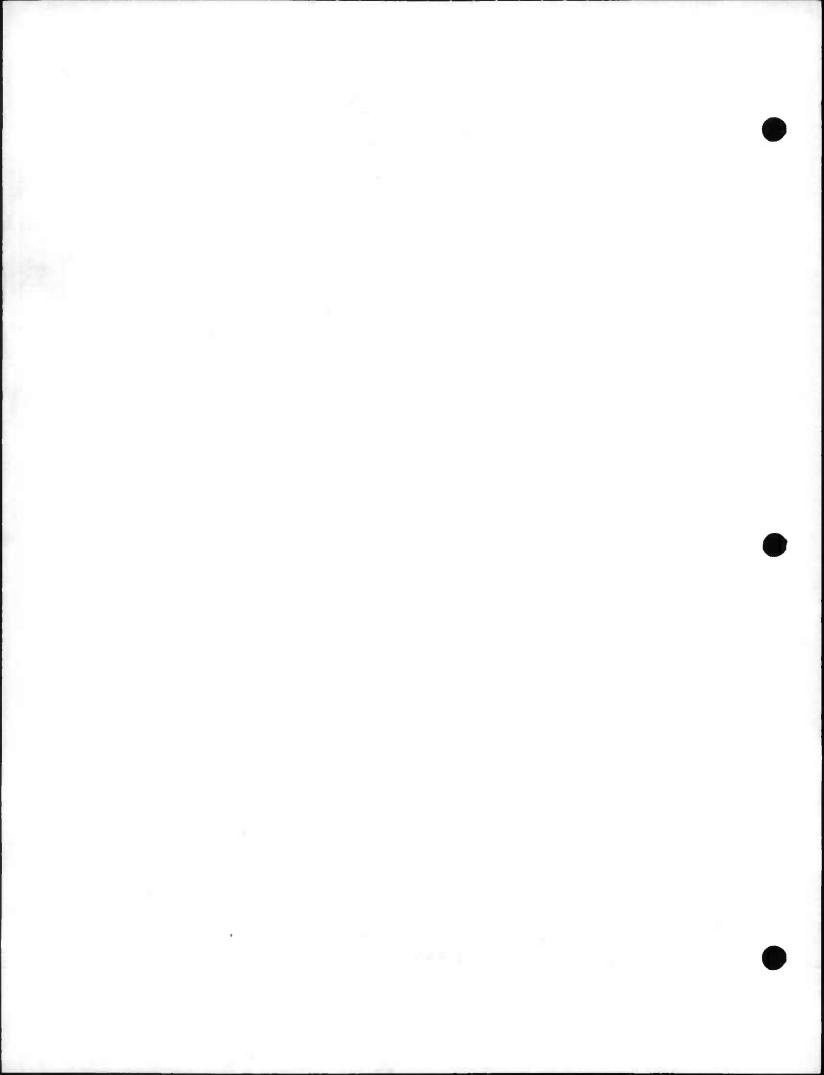
93 08629 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Raymond Joyner 28 1993 7:45 A M March 8. AGE (In yrs. last birthday)
72 YRS. 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) N. C 242-18-8552 1 M 2 | F DAYS HOURS MIN. N.C. 9a. FACILITY NAME (If not institution, give street and number) 96. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Maryland General Hospital Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md Baltimore City 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? SA 1701 Eutaw Place U 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 V YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, P

1 YES 2 NO Specify: 1 Never Married 2 Married **B1ACK** BY Specify: 3 🕅 Widowed 4 🗌 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
179/we kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 166. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) 7th College (1-4 or 5+) Laborer once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Sam Joyner Hattie Sutton BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 5210 Lightningview Road Columbia, Md 21045 <u>Bobby Joyner</u> å 20a. METHOD OF DISPOSITION
1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 20c. LOCATION — City or Town, State
Caton sville, Md 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must ^{co}Metrocrematory 33093 4 Donation 5 Office (Specify) medical examiner IL SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, Approximate shock, or heart feliure. List only one ceuse on each line. intervai Betwe **IMMEDIATE CAUSE (Final** Onset and Death the disease or condition Lung Cancer And Pneumonia event, resulting in death) Metastasis to brain and overwhelming traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEDUENCE OF): cause. Enter UNDERLYING Respiratory Failure CAUSE (Disease or Injury or other DUE TO (DR AS A CONSEDUENCE OF): that initiated events resulting in death) LAST PART ii. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? shows any 1 YES 2 NO 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNEW OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural
2 Accident 5 Pending Investigation 1 YES 2 ND ВУ 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is COMPLETED If Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated.

ME AND ADDRESS OF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph Robinson, M.D. C/O Maryland General Hospital 827 Linden Avenue 32. TEGISTRAR'S SIGNATURE

2 ___ MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. DATE SIGNED (M)



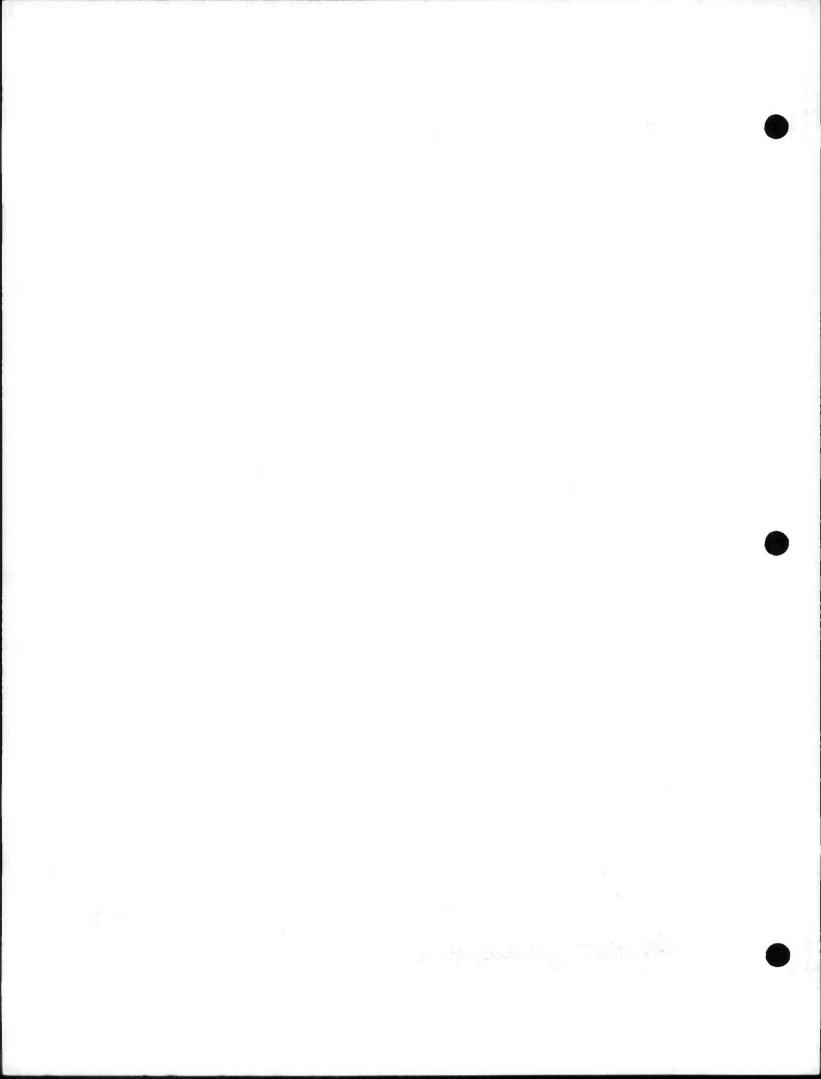
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

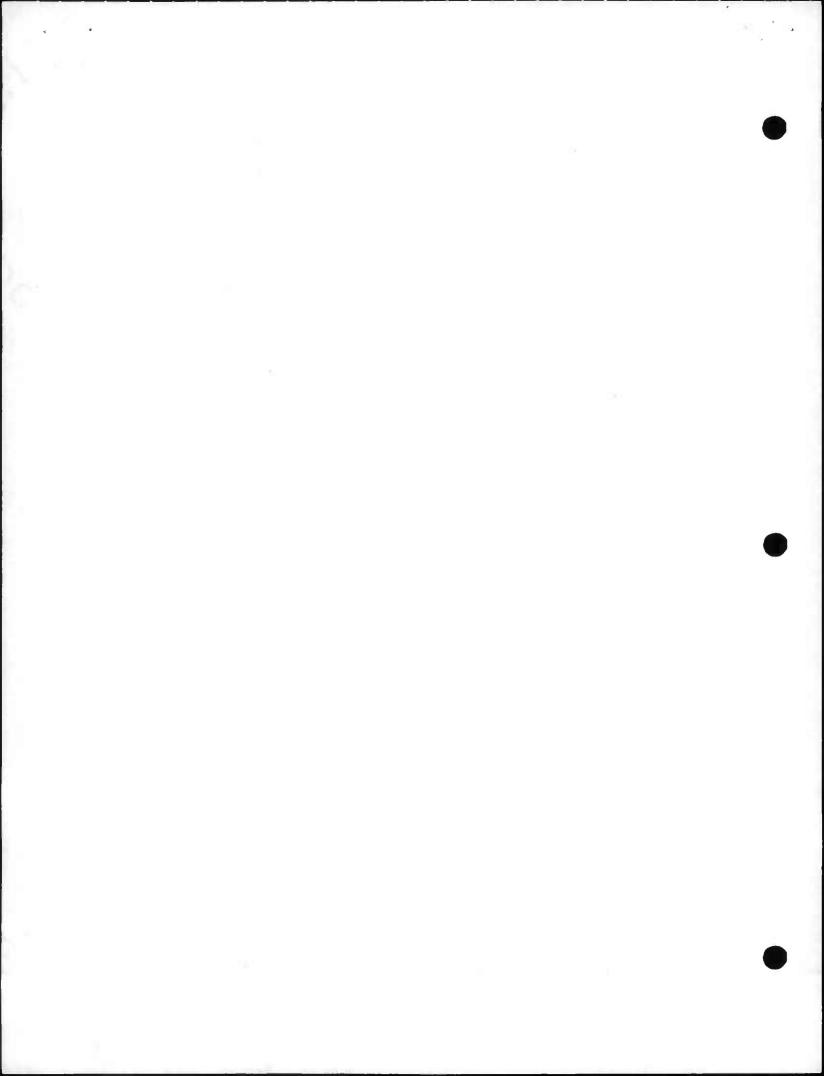
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF H		MENTAL HYGIEN				
1	1. DECEDENT'S NAME (First, Middle, Last) Tegele	R	Jaci	kson		2. DATE OF DEATH MONTH D	v ye	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 216-48-3091	5. SEX 6. AGI	E (Inlyrs. last birthday) 45 YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	6.1	BIRTHPLACE (State or Foreign Country)		
H)	9a. FACILITY NAME (If not institution, give at	reet and number)		96. CITY, TOWN O	R LOCATION OF DE		9c. COUNTY	OF OEATH		
5	RESIDENCE OF DECEDENT	114		04/1						
DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	y, town or locat Balto	LIMITS?					
FUNERAL	3602 Callo	way Ave		101	21215		10g. CITIZEN	CITIZEN OF WHAT COUNTRY?		
	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER FORCES? 1 YES	S 2 NO	If yes, spi	cify Cuben, Maxica	NIC ORIGIN? (Specify Yes	or No — 14.	RACE — American Indian, Black, White, etc.		
ED BY	3 Wildowed 4 Divorced 15. DECEDENT'S EDUC	IF YES, GIVE WAR OR		1 TYES				specify: Black		
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of life. Do NOT us	USUAL OCCUPATIO work done during mos se retired.)	iN st of working	16b, KIND OF BUS	SINESS/INDUST	RY		
COMPL	17. FATHER'S NAME (First, Middle, Lest)				46 1405145740 144		V - V - V			
BE C	Thurlow S	Tackson			Hilda	ME (First, Middle, Meiden	ins			
5	The ma Bal	dwin	360	2 Call	Number or Rural F	Ave Bo	n, Stele, Zip Coo	40 21215		
	205 METHOD OF DISPOSITION 1/ Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	eval from State 20	Db. PLACE AND DATE, emellery, crematory or o	of DISPOSITION (Net	t llot	7/3/93 OL	CATION - City	or Town, State Hills Hd		
	21. SIGNATURE OF HONE AL SERVICE LICE	ENSEE)		D ADDRESS OF FA	CHUTY Was 7	1	1,112,124		
	23. PART I. Enter the diseases, or complications thet caused the death bo not enter the mode of dying, such as cardiac or respiratory errest, Approximate									
	shock, or heart failure. I IMMEDIATE CAUSE (Finei disease or condition resulting in death)	iat only one cause on	aach lina.		segne		l al	Approximata Interval Between Onset and Death		
7	DUE TO (OR AS A CONSEQUENCE OF):									
ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS	A CONSEQUENCE OF	F):						
CERTIFICATION	CAUSE (Diseese or injury that Initiated events resulting in death) LAST	OUE TO (OR AS	A CONSEQUENCE OF	F):						
	PART ii. Other aignificent conditions	s contributing to deeth	but not resulting	in the underlying	Cause Given in	Part i. 24a. WAS AN	ALITTOREY T	24b. WERE AUTOPSY FINDINGS		
ICAL			out not resulting	in the underlying	couse given in	ERFOR	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE		
: MEDIC						will t		OF DEATH? 1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			28. PL	ACE OF DEATH (Che	eck only one)				
YSIC	1 TES 2 NO	HOSPITAL:	tpatient 3 DOA	OTHER: 4 Nursing Home	5 - Residenca	8 Other (Specify)				
ву Рн	27. MANNER OF DEATH 1 Vertural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		URY WOI	IRY AT RK? ES 2 NO	28d. OEŞCRIBE HOW II	JURY OCCURE	ED		
	3 Suicide 6 Could not be determined	28e. PLACE OF INJUR building, atc. (Sp	RY — At home, ferm, ecify)	street, factory, office		28f. LOCATION (Street a City or Town, State)	nd Number or R	ural Route Number,		
COMPLETED		CIAN: To the best of my kno						use(a), end manner as stated.		
BE CC	291 SIGNATURE AND TITLE OF CERTIFIER		1~		29c. LICENSE NUN	BER/ (C		SHEET (Morning Day, Year)		
D .	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	EAT (ITEM 27) (1) par	Print)	-D 25	2602	P 0	No 71		
	31. DATE HED (Month, Clay Hear)	32. SEGISTRAR'S SIG	NATURE	1 ha	100	mar	RI	15		
	MAN 3(1) (933) 9	which Deviden 1	andelle	· · · · · · · · · · · · · · · · · · ·				DHMH-16 Rev 1/89		



		1 - STATE REGISTRAR	SIAIE UF MARTL			F DEATH	MENTAL HYGIE REG. N			
			UNG Ruth	n M. Lew	ris			29 g	3. TIME OF DEATH 3 5:15 PM	
		077 07 07 17	5. SEX 6. AGE (1	In yrs. last birthday) YRS.	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year) Oct. 15,		BIRTHPLACE (State or Foreign Country) Maryland	
3 should		9a. FACILITY NAME (If not institution, give street			9b. CITY, TOV	/N OR LOCATION OF		9c. COUNTY	4	
2, 3 s	CTOR	Mercy Hospital			Ba.	ltimore				
Pages 1.	ш	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. C/1	Y, TOWN OR LO	CATION		10d, INSIDE CITY		
permit. Pa	DIR	Maryland				Baltimor	e			
	ERAL	3200 Ramona Ave.				101. ZIP CODE 212	10		OF WHAT COUNTRY?	
020 physician. burial-transit	FUNE	11. MARITAL STATUS	2. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS	DECENDENT OF HISP	ANIC ORIGIN? (Specify Y		S. A. RACE — American Indian,	
21215-0020	BY	1 Never Married 2 Married 3 WWidowed 4 Divorced	FORCES? 1 YES	ZXJNO NTES	1 🗀 '	, specify Cuben, Mexi /ES 2 NO Spec	can, Puerto Rican, etc.) offy:		Bleck, White, etc. Specify: White	
121	ETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	mpleted)	16e. DECEDENT'S	WORLD OCCUP work done during se retired.)	ATION most of working	16b. KIND OF B	USINESS/INDUST	RY	
	[일		College (1-4 or 5+)		maker		Own :			
MARYLAND retained by the hospit 5 should be detacted	i limit	17. Father's Name (First, Middle, Last) John Patrick Maher	<u> </u>				la Schmidt			
E, MAR y be retained yage 5 should be putified		James H. Lewis III	[(Son)	196. MAILING 805 B	enjamir	et and Number or Rure 1 Rd., Be	il Route Number, City or To 1 Air, Md.	wn, State, Zip Cod 21014	(e)	
MORE, I		20s, METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)		PLACE AND DATE etery, crematory or or Daklawn			1	ocation — city Baltimo:		
ALTIMOR death. Page 6 ma funeral director, p		21. SIGNATURE OF FUNERAL SERVICE LICEN			22, NAM	AND ADDRESS OF	FACILITY		ic, ra.	
- 9 m		Jh 7,	Silli		333	31 Brehms	uneral Hom Lane, Bal	timore.	Md. 21213	
24 hours / filled in t tion, or re-		23. PART I. Enter the diseases, or conshock, or heart failure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	pplications that caused at only one cause on ea	ich iine.			ch as cardiac or res	piratory arrest,	Approximata Interval Between Onset and Death	
pe un la			DUE TO FOR AS A	CONSEQUENCE	த): ≪்					
OX 68 be be execut sician and crior to buniteralization	CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING	DUE TO (DR AS A	CONSEQUENCE O	F):					
phy phy	FIC	CAUSE (Disease or Injury that initiated events CAUSE (DISEASE OF):								
7 - 5 - 5	ERT	resulting in death) LAST								
at the death by the attendental Heart Hear	L C	PART II. Other significant conditions of	contributing to death bu	ut not resulting	in the underl	ying cause given i	n Part I. 24a. WAS A	IN AUTOPSY	24b. WERE AUTOPSY FINDINGS	
signed tealth							1 TYES	PRMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
VIIAL KE AN: The law requificate has been: State Dept. of Pritem 23 short	Z	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				PLACE OF DEATH (Check only one)			
SICIAN: The certificate the State	YSIC	1 YES 2 ND 1	OSPITAL: Unpetient 2 ER/Output				8 Other (Specify)			
DING PHYSIC After this ce death with the	ВУ РНУ	27. MANNER DF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE DF INJURY (Month, Day, Year)	26b. TiN	JURY	INJURY AT WORK? YES 2 NO	26d. DESCRIBE HOW	INJURY OCCURE	ED	
TTENDI TTENDI CTOR: A after d	유	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Speci	— At home, farm,	street, factory, o	ffice	281. LOCATION (Stree City or Town, State		lural Route Number,	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	5	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA CERTIFICA CERTIFICA CERTIFYING PHYSICIA CERTIFICA CE							use(a) and manner as stated.	
	BE CC	296. SIGNATURE AND TITLE OF CERTIFIER		5		29c, LICENSE N			GNED (Month, Day, Year)	
TO THE De filed	10 B	NOWM	m	U.				131	29/93	
		30. NAME AND ADDRESS OF PERSON WHO C	CO CL	ATH (ITEM 27) (Type	Print)	saltin	nove.	MD		
		31. DATE TILED (MORITI, Day, Year) MAR 3 1 1993	32. REGISTRAR'S SIGNA	Rando		, ,				
		/	1	A Tarachaman						



DIVISION OF VITAL R	DAY PHYSICIAN: The law rec	the this certificate has be	with the State Dept.	marked, or item 23 :
STANIO	TO THE HOSPITAL OF ATTEM	TO THE FUNERAL LIFET TO ATTENTION CONTINUES DEED	be filed within 72 hands attended	IMPORTANT: It liem 26 to marked, or item 23 sh

PHYSICIAN: The law requires that the death certificate be executed within 2 mours after death. Page 6 may be retained by the hospital or attending is	we this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the		- 4
the h	detac		OUC
2	be		F
retained	5 should		the insisted, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitled at once.
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purial-transit permit. Pages 1, 2, 3 should

93 08632 FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 2. DATE OF DEATH MONTH MATCH 27, 1993 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH Ethel Murray 3:52 P 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 V F 212-16-4420 YRS. 85 3-1-08 MD 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Maryland General Hospital Baltimore City RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY MD Baltimore 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4112 The Alameda 21218 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THOU IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES XINO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY Black 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) Elementary/Secondary (0-12) 9th Notre Dame 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Gray Emma Spriggs 86 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ella Hardy 4112 The Alameda/Baltimore, MD 21218 20a, METHOD OF DISPOSITION
1 💢 Buriel 2 🗆 Cremation 3 🗆 Removal from Stata 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Baltimore Cemetery 4 Donation 5 Other (Specify) Baltimore, 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY WM C. MARCH F.H./1101 E. NORTH AVE. 23. PART I. Enter tha diseases, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List Dnly Dne cause Dn aach line. Interval Betw **IMMEDIATE CAUSE (Final** Onset and Death diseese or condition Septic shock resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Respiratory failure CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury Severe bilateral pnuemonia DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PHYSICIAN: MEDICAL

PART ii. Other significent conditions contributing to death but not resulting in the unc	deriying ceuse given in Part i.

24a. WAS AN AUTOPSY 1 TYES 2 THO

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 - NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 - YES 2 XX10

27. MANNER OF DEATH

1 XX Xiatural

2 Accident

3 Suicide

4 Homicide

BY

BE COMPLETED

2

HOSPITAL: OTHER: 4 🔲 Nurs 28a. DATE OF INJURY (Month, Day, Year)

26. PLACE OF DEATH (Check only one) ng Home 5 - Residence 6 - Other (Specify)

28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO

28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)

281. LOCATION (Street and Number or Rural Route Number City or Town State)

3

27

93

29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the besia of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

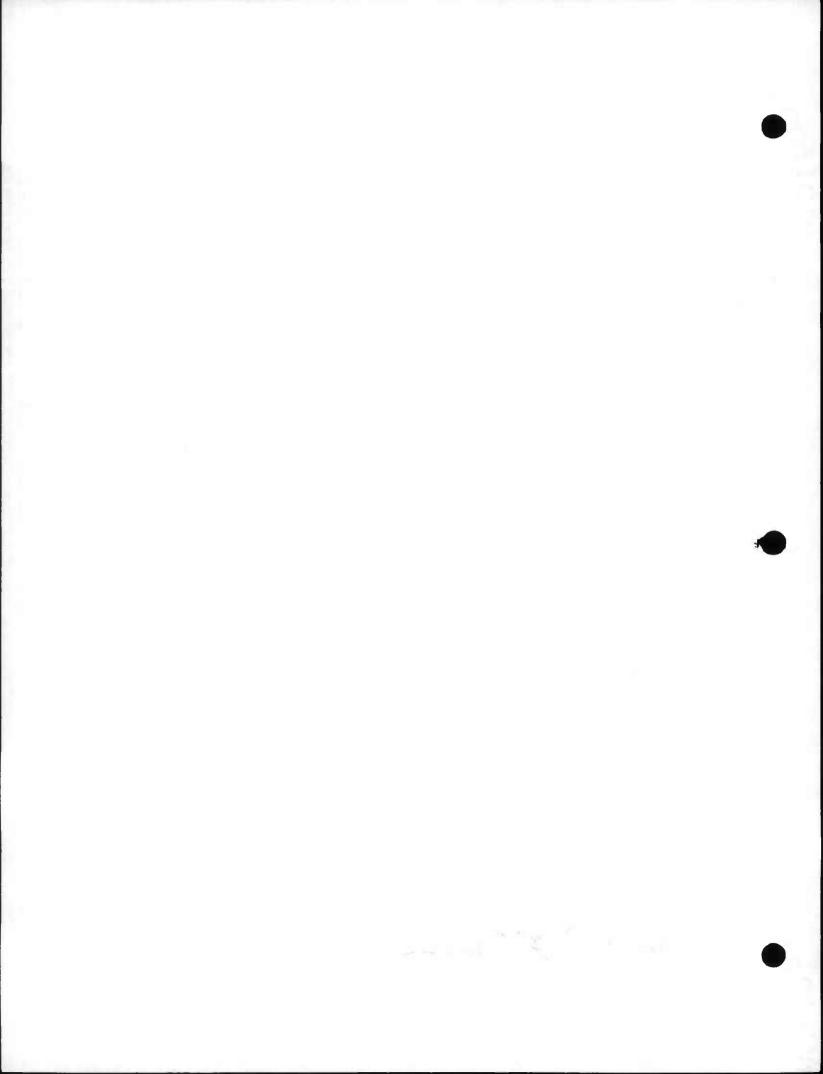
29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mogth, Day, Your) PGYI

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

BELEN CLO MARYCAND GENERAL HOSPITAL

8 Could not be determined





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			4. SOCIAL SECURITY NUMBER 218-14-5773	5. SEX	6. AGE (In y	rs. lest birthday) YRS.	IF UNDER 1 Y		F UNDER 24 HRS. OURS MIN.	7. DATE OF (Month, D		•	Country)	ACE (State or Forei
	2, 3 should	TOR	9a. FACILITY NAME (If not institution, ght BUHWOU VA U RESIDENCE OF DECEDENT		ter		86. CITY, TO Balti		OCATION OF OE		7.	9c COUNTY		rginia M N/A
	nit, Pages 1,	DIRECTOR	10a. STATE 10b. COU	Honere Green			y, town on							d. INSIDE CITY LIMITS?
-	nsit pern	FUNERAL	100. STREET AND NUMBER 570 Maushall A	tue., Baltin	Lore 1	40			P CODE 21208			10g. CITIZEI		T COUNTRY?
215-0020 attending physician.	the burial-transit permit, Pages	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS OECEDENT FORCES? 1 [IF YES, GIVE WI	EVER IN U.S YES 2 OR DATES	S. ARMED	Ну	S DECENO es, specify YES 2	DENT OF HISPAN y Cuban, Mexican NO Specify	n, Puerto Rica	Specify Yea n, atc.)			American Indian, Thite, etc. Whj.
5	d for use as	COMPLETED	15. DECEDENT'S E (Specify only highest gr Elementary/Secondary (0-12)			Itle. Do NOT us	work done dun	ing most of		16b. KII		od Ind		
ND No hospital	detached once.	E COM	Grammer 17. FATHER'S NAME (First, Middle, Last)							ME (Elent Mide			lusti	У
YLA by the	2 %		JOhn Clendenn Virginia Miller											
g m	5 should notified	00	19a. INFORMANT'S NAME (Type/Print)		19b. MAJLING	ADDRESS (S	Street and h	VII GIII			, State, Zip Co	ode)	7	
-		2	Iris Gwyer					x 342, E				1074		
ALIIMORE death. Page 6 may e funeral director, pa		20a. METHOD OF DISPOSITION 1	cemetar	LACE AND DATE OF DISPOSITION (Name of iry, crematory or other place)			DATE	7	CATION — CIT	y or Town,	State			
		Ronald Wade, Dir 3/29/93 655W.BaltimoreSt, Balto, MD 21201												
50, within 2- nours	within 2- riburs aff spletely filled in by cremation, or remo		23. PART I. Enter the diseases, cahook, or heart failur investigate or condition resulting in death)	a. Sopsis	OR AS A CO	pului	onary Fi:			n se cardiac	or reapir	ratory arrea	t,	Approximate intervel Betwoonset and D
P.O. BOX 687 of certificate be executed	ending physician and co Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	b. Renal. DUE TO (1) C. G.I. blu DUE TO (1) d. DISSEMI	UR AS A CO	NSEQUENCE OF	F):	al C	coagula	tion				
requires that the deal seen signed by the att of Health and Merra shows any injury,	sen signed b of Health ar	MEDICAL	PART II. Other significant conditions of Structure of Str					riying ca	Ause given in I	Part i. 24	PERFORI	MED?	OF	RE AUTOPSY FIND ALABLE PRIOR TO MPLETION OF CAU DEATH? YES 2 109
_ F	certificate has be the State Dept. d, or item 23	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 HO	HOSPITAL:	ER/Outpatie	nt 3 DOA	OTHER:		OF DEATH (Che					
J E	新年	Y PHYSIC	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF I (Month, Day	NJURY	28b. TIM	E OF 28	c. INJURY WORK?	AT			JURY OCCUP	RED	
OR ATTENDING PHYSICIAN:	after d	TED BY	2' Accident Investigatio 3 Suicide 8 Could not to 4 Homicide detarmined	28e. PLACE OF	INJURY — I	At home, farm, s	street, factory	, offica			ON (Street as own, State)	nd Number or	Rural Route	a Number,
7	Z 02 == 1	COMPLET		YSICIAN: To the best of m									ause(s) an	d manner as state
TO THE HOSPITAL	TO THE FUNERA De filed within 7 IMPORTANT: 1	TO BE C	29b. SIGNATURE AND TITLE OF CERTIF	Klidial							29d. DATE S	IGNED (MG	onth, Day, Year)	
		F	RICHARD Chen H	P UNIV OF	E OF DEATH	OTEM 27) (Type.	Prine) 15. DY	pl. H	led. 225	s. Gree	ne st	- Bal	10.00	0 2120/

32 (EGISTRAR'S SIGNATURE

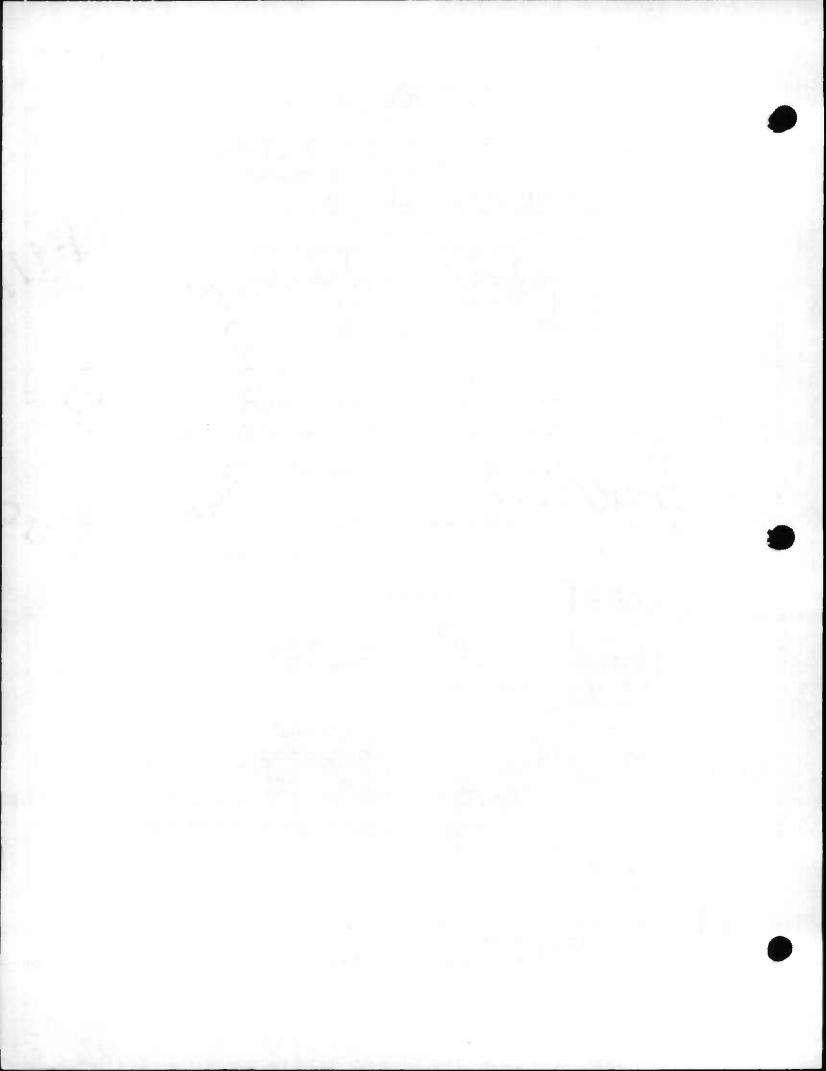
FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

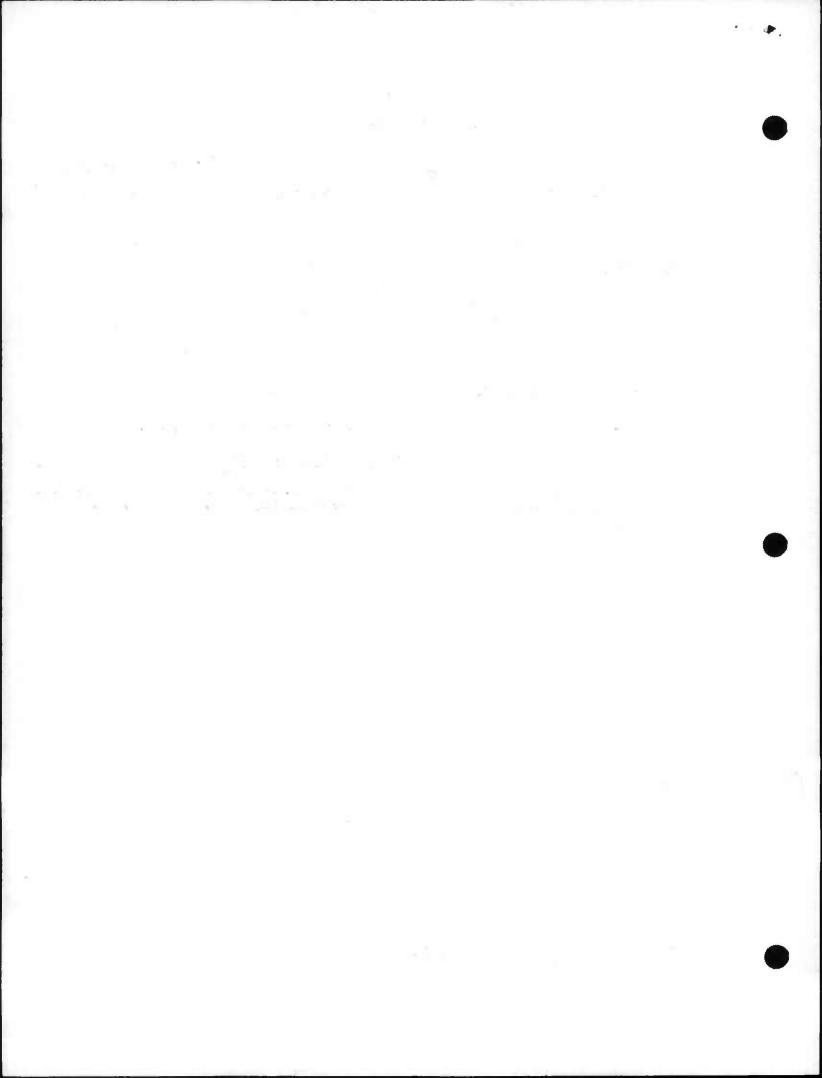
Harold D. Wartin

HAROLD DONALD MARTIN

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 2. DATE OF OEATH 3-25-3. TIME OF DEATH 9:36 03 8. BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTH (Morith, Day, Year) 1 YEAR IF UNDER 24 HRS. MIN. W Virginia TOWN OR LOCATION OF OEATH 9c COUNTY OF OEATH N/A 10d. INSIDE CITY 1 PES 2 NO 10g, CITIZEN OF WHAT COUNTRY? 21208 WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 U YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. White 16b. KIND OF BUSINESS/INDUSTRY Food Industry 18. MOTHER'S NAME (First, Middle, Maiden Surname) Virginia Miller (Street and Number or Rural Route Number, City or Town, State, Zip Code) St Box 342, Hampstead, MD 21074 DATE 20c. LOCATION — City or Town, State NAME AND ADDRESS OF FACILITY State Anatomy Board 5W.BaltimoreSt,Balto,MD 21201 the mode of dying, such as cardiac or reapiratory arrest, Approximate Onset and Death las coagulation derlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO 1 | YES 2 | MO 26. PLACE OF DEATH (Check only one) ng Home 5 Residence 8 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) me, date and place, and due to the cause(s) and manner as stated. pinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) 1 3/25/93 VAMC 41205BJ



		1 - FOR STATE REGISTRAR		D / DEPARTMENT CERTIFICATE	OF HEALTH AND W	IENTAL HYGIENE REG. NO.	de	
		1. DECEDENT'S NAME (First, Middle, Last) Chules Lev Ma	Charles	Leo Mangu	m	2. DATE OF DEATH DAY	PEAR	3. TIME OF DEATH
pin	- 1	10 10 10	M2 DF	YRS.	DAYS HOURS MIN.	7. DATE OF BURTH (Month Of Cyper) 2	1936 Country)	aryland
1, 2, 3 should	DIRECTOR	9a. FACILITY NAME (If not institution, give street an 965 Ramsey Place	Parl	96. CITY, 1	Toppatowne	тн	9c. COUNTY OF DEA	ord
permit. Pages 1,			ford	Joppato	Control of the Contro			IOd. INSIDE CITY LIMITS? I YES 2 NO
\$ is	FUNERAL	965 Rumsey Place			21085		10g. CITIZEN OF WH USA	AT COUNTRY?
15-0020 ending physician. as the burial-transit	В	1 Never Married 2 Married F	AS DECEDENT EVER IN U.S ORCES? 1 X YES 2 YES, GIVE WAR OR OATES MATINES	□NO If	AS DECENDENT OF HISPANII yea, specify Cuban, Maxican, YES 2 NO Specify:	C ORIGIN? (Specify Yes of Puerto Rican, atc.)	or No — 14. RACE — Black, 1 Specify: Whit	
D 2121 pital or atte	TO BE COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade comple Elementary/Secondary (0-12) Colk	(tod) 16a	(Give kind of work done du life. Do NOT use retired.)	ring most of working	166. KIND OF BUSH	ness/industry	
YLAN 1 by the hos d be detach d at once.		17. FATHER'S NAME (First, Middle, Last) Roland Joseph Mangu	m, Sr.		18. MOTHER'S NAM Jewell	E (First, Middle, Maiden S Ann	'umame)	
E, MAR y be retained bage 5 should be notified		19a. INFORMANT'S NAME (Type/Frint) Tina M. Mangum		196. MAILING ADORESS (171 School)	Street and Number or Rural Ro house Lane,	conowingo,	State, Zip Code) Md. 219	18
Page 6 may all director, page must b		20e. METHOD OF DISPOSITION X Burlel 2 Cremation 3 Removal fr 4 Donation 5 Other (Specify)	om Stata cometan		orial Garden	18 dz		more, Md.
ALT death. e funera li.	25	21. AIGNATURE OF FUNERAL SERVICE LICENSEE	The same	31	AME AND ADDRESS OF FACI ANS FUNSE TEMPORT DR	SIVE FORE	LLIK TO	
SO, within 24 hours pletely filled in the cremation, or referent, the median		23. PART I. Enter the diseases, or compliance, or heert failure. List of iMMEDIATE CAUSE (Finel disease or condition resulting in death)	nly one ceuse on each	deeth. Do not anter the	ne mode of dying, such	as cardiec or reepire	atory arrest,	Approximata interval Between Onset and Death
P.O. BOX 68: The certificate be executed and control physician and control Hydiene prior to burian or other traumatic.	CERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in desth) LAST	DUE TO (OR AS A CON					
RECORDS equires that the d en signed by the of Health and Mer	MEDICAL	PART II. Other significent conditions con	tributing to death but n	ot resulting in the unde	eriying cause given in P	art I. 24a. WAS AN A PERFORM 1 TYES 2	MED?	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE IF DEATH? YES 2 100
AL has has Dep	SICIAN:		PITAL:	OTHER:	26. PLACE OF OEATH (Chec			
this certification with the Ked, or	Y PHYSICI	27. MANNER OF DEATH 1 Natural 5 Pending	Ba. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 20	g Home 5 Residence 8 8c, INJURY AT WORK? 1 YES 2 NO	Other (Specify) 28d. DESCRIBE HOW IN.	JURY OCCURED	
ISIC TTEIND TOR: A after d	TED BY		8e. PLACE OF INJURY — A building, atc. (Specify)	t home, ferm, street, factory		28f. LOCATION (Street and City or Town, State)	d Number or Rural Rou	te Number,
DI TAL OR AL DIR 72 hours	COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: T			e, date and piece, and due to			nd manner as stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72	O BE C	296. SIGNATURE AND TITLE OF CERTIFIER	L. Coefer	red Efum	29c. LICENSE NUMB	194	29d. DATE SIGNED (M	fonth, Day, Year)
	F	30. NAME AND ADDRESS OF PERSON WHO COM	9739	(ITEM 27) (Type, Print) FER My	2013 Days	Tarple	Thurch!	RAY
		MAR 3 1 1993 Juli	2. RESISTRAR'S SIGNATUR DavidSon-Rand	A.S.Z.		7		



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BALTIMORE, MARYLAND 21215-0020	SIGNAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Mental Hygiene prior to bunial, cremation, or removal.	he medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the se fied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	MPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF M	IARYLAND /			OF DEA		MENTAL		_E 9.	3 0	8635		
	1. DECEDENT'S NAME (First, Middle, Last)	5	MOORE		IOAI L	OI DEA		MONTH			YEAR 3	TIME OF DEATH		
į.	4. SOCIAL SECURITY NUMBER 216-22-4773	1 - M 2 - F	6. AGE (In yrs. last	birthday) YRS.		MYS HOURS	R 24 HRS.	(Month)	DE BIRTH Day, Year)	5	MARY	ACE (State or Foreign		
TOR	9a. FACILITY NAME (If not institution, give s GRMC_6701_N_CHAR) RESIDENCE OF DECEDENT		LTO MD	TO MD BALTIMORE						TIMOF				
DIRECTOR		Y ALTIMORF (COUNTY							10d. INSIDE CITY LIMITS? 1 YES 2 M NO				
FUNERAL	7433 FORREST AVE	NUE 12. WAS DECEDENT	FVFR IN U.S. ARM	MT)	12 140	2123	4	NC OBIGIN	2 Canality Man	U	16g. CITIZEN OF WHAT COUNTRY?			
à	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1	YES 2 NO		If y	es, specify Cub YES 2 NO	nh, Mexica	n, Puerto R		or No—	Black, \ Specify:	RACE — American Indian, Black, White, etc. Specify: WHITE		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(G/v	e kind of w Do NOT us	USUAL OCCI work done duri e retired.)	ing most of work	ing	16b.	KIND OF BUS	INESS/INDI	USTRY			
BE CON	17. FATHER'S NAME (First, Middle, Last) EARL SH	AFFER				18. MOT	HER'S NAI	ME (First, M	fiddle, Maiden	Surramo) HLM	NY			
٩	FAMILY PE	COPDS		SA	me	Street and Number	or or Rural F	BOVE	25					
20s. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 20b. PLACE AND DATE OF DISPOSITION (Name of Chipselly, crematory, crimatory,									UE, MD.					
	Jeppen 7	gain	mo06	77	El 8	19NS 800	Fyi	VER.	AL C	DA	PAR	KVILLE		
	23. PAPT I. Enter the diseases, or check, or heart failure. IMMEDIATE CAUSE (Finei disease or condition resulting in death)	a. C.V.A	caused the dease on each line.			e mode of dy	ring, suct	h as cerd	liec or respi	ratory arm	est,	Approximate interval Between Onset and Death		
CATION	Sequentially list conditions, if any, leading to immediate	b A.S.C	V.D.	LIENCE OF								i		
ERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	_ ATRIA	L FIBRIL	LATI	ON									
MEDICAL CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. ATRIAI	L FIBRIL OR AS A CONSECU CEMIA	LATI UENCE OF	ON D:	orlying ceuse	given in	Part I.	24a. WAS AN PERFOR	MED?	0	ERE AUTOPSY FINDINGS WALLABLE PRIOR TO OMPLETION DF CAUSE F DEATH? YES 2 \(\text{NO} \)		
_ 1	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. ATRIAI	L FIBRIL OR AS A CONSEON CEMIA deeth but not re	LATI UENCE OF	ON n the unde	orlying ceuse 26. PLACE OF I	DEATH (Che	ock only one	PERFOR 1 TYES 2	MED?	0	MAILABLE PRIOR TO OMPLETION OF CAUSE IF DEATH?		
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the attending physician and completely filled in by the 3 Mental Hygiene prior to burial, cremation, or removal. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within been signed by the of Health and N has be Dept. r this certificate ha DIRECTOR: After the hours after death w TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2

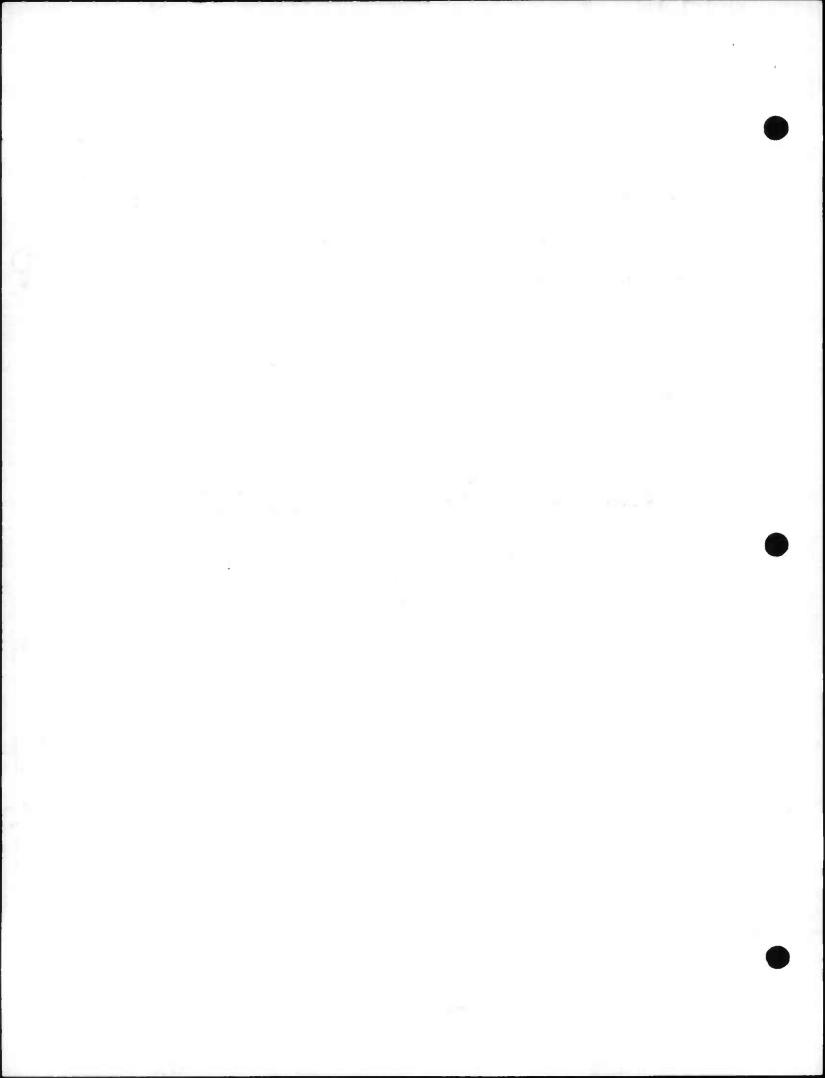
08636 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF CEATH YEAR HEDWIG **MEISTER** 3 93 11:45AM M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in vrs. lest birthdey) IF UNDER I YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) (Month, Day, Year) 1-23-1909 1 - M 2 -F DAYS HOURS 214-30-5329 84 YRS. Germany 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH Shady Grove Medical Center DIRECTOR Rockville Mon Tgomery RESIDENCE OF DECEDENT tob. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Gaitherburg 1 YES 2 XXNO 10e. STREET AND NUMBER BY FUNERAL 101. ZIP CODE tog. CITIZEN OF WHAT COUNTRY? 315 Summit Hall Rd. 20877 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X 100 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—if yee, specify Cuben, Mexicen, Puerto Ricen, atc.)

1 □ YES X N ND Specify: 14. RACE 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES 3/X Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Housewife & Seamstress Homemaking 17. FATHER'S NAME (First, Middle, Last) ta. MOTHER'S NAME (First, Middle, Meiden Surname) Gustav Wenzlowski Rosalinda Bon Trishinski BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Elizabeth Huber 315 Summit Hall Rd. Gaithersburg, Md. 20877 20e. METHOD OF DISPOSITION
t □ Burlat 2 X Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State cemetery, crematory or other place) Metro Crematory Inc. 4 Donation 5 Other (Specify) 3/30/93 Baltimore. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home Junerel Vom E assek 7401 Belair Rd. Balto Md. 23. PART 1. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, **Approximate** ahock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) CERTIFICATION Sequentisity list conditions, If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (DR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? t TYES 2 NO 1 TES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER:
4 \(\text{Nursing Home} \) 5 \(\text{Recidence} \) 6 \(\text{Other (Specify)} \) 1 YES 2 ND 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 26b. TIME OF 28c. INJURY AT WORK? INJURY 1 Netural 1 YES 2 ND BY 2 Accident 26e. PLACE OF INJURY - At home, lerm, street, factory, office 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be 4 Homicide 29e. CERTIFIER

Interval Between Onset and Death COMPLETED 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Mogth, Day, Year) 39 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE a Saighan Mordall MAR 199 DHMH-16 Rev 1/89

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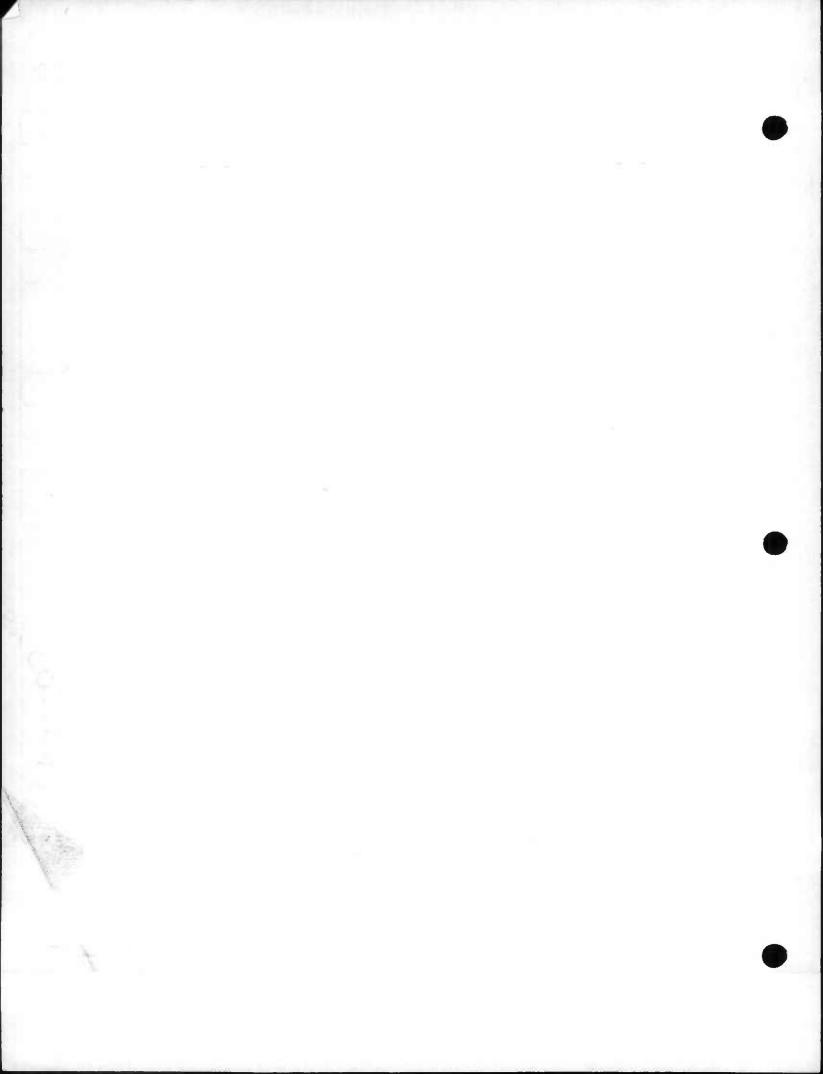
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Đ	8	4. SOCIAL SECURITY NUMBER 215-34-9088	3	5. SEX 1 \(\overline{\chi} \) M 2 \(\overline{\chi} \) F	6. AGE (fr	in yrs. lest	YRS,	IF UNDER	1 YEAR DAYS	IF UNDER	R 24 HRS.	7. DAT	E OF BIRTN onth, Day, Year) G. 29, 19			LACE (State or Foreign
3 should	œ	9e. FACILITY NAME (If not ins						9b. CITY,	TOWN C	OR LOCATI	ON OF DE	_			NTY OF DEA	
1, 2,	RECTOR	UNIVERSITY RESIDENCE OF DEC	EDENT	SPITAL			BALTIMORE CITY									
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permit. Pages	AL C	10e. STREET AND NUMBER					BALTIMORE 109, CITIZEN OF WH					YES 2 NO				
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21215-0020 all or attending physician. for use as the burial-transit	BY FUNI	11. MARITAL STATUS 1 Never Merried 2 1 3 Widowed 4 Divor	43777	12. WAS DECEDENT FORCES? 1 IF YES, GIVE V	1 X YES	2 N						or No—				
1215 r attend use as	9	15. DECE (Specify only	EDENT'S EDU	CATION completed)		16a. DEC	CEDENT'S	USUAL OC	CCUPATIO	ON of worki	97	1	6b. KIND OF BUS	INESS/INC	DUSTRY	MILLE
the hospital or detached for u	COMPLET	Elementary/Secondary (0- 8 TH GRAD	-12))E	College (1-4 or 5	+)	life.	Do NOT us	RUCT]		St of works	ng .		·			
8 8 Z	BE CO	WILLIAM M	R'S NAME (First, Middle, Last) ILLIAM MILLER RMANT'S NAME (Type/Print)							MA	TILD	A G				
MAR retained 5 should notified	2		19b.							mber, City or Town			21122			
ORE, 6 may be ctor, page		20a. METNOD OF OISPOSITIO	ROBIN LAWRENCE 306 RAYFORD ROAD - PASADENA, MARYLAND 21122 20e. METNOD OF OISPOSITION 1 57 Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MEADOWRIDGE MEMORIAL PARK 04/01 ELKRIDGE													
FIMOR Page 6 ma al director, p		21. SIGNATURE OF FUNERAL		ENSEE /	I ME	ADO	IRID				PARK SS OF FAC		/01l_EL	KRID	GE	
BALTIM after death. Page by the funeral dire- moval.	1	- Wariul	the	Muso	>			41	07	WTT.K	ENS	AVE	HOME, I	TTMO	RE. M	0. 21229
24 hours filled in thion, or relate med		ahock, or haart fallure. List only one cause on each line.										Approximata Interval Between Onset and Daath				
X 68 execution and company to burie	CATION	Sequentially list conditions, If any, leading to immediate b. OUE TO (OR AS A CONSEQUENCE OF):														
certificat oding phy Hygiene p	CERTIFICA	cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in daath) LAST d.														
0) 0 0 0 0		PART II. Other significan	nt condition	s contributing to	death bu	Jt not re	sulting	In the un	derlying	r cause	alven in	Part I.	24a. WAS AN	AUTOPSY	24b, W	PERE AUTOPSY FINDINGS
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IAN:	HYSI	1 X YES 2 NO		1 Inpatient 2		rtient 3 (ing Home	_	sidence		her (Specify)			
Z 0 35 2	ву рь	1/X Netural 5 🗆 P	Pending nvestigation	28e. DATE OF (Month, D	Day, Year)		_	M	1 🗌 Y	PK? ES 2	NO	28d. D	EŞCRIBE HOW II	IJURY OC	CUREO	
OH ATTENDING DIRECTOR After Nours after death Hern 28 is ma	ETED.	4 Homicide d	Could not be letermined	28e. PLACE O building,	OF INJURY - , atc. (Specif	— At hon	ie, ferm, s	street, facto	ory, office			281, LC	CATION (Street e ty or Town, State)	nd Number	or Rural Rou	te Number,
걸정산=	COMPL			CIAN: To the best of R: On the besis of a												nd menner ee stated,
THE HOSPI FIRE FUNE Bed within	BE (299 SIGNATIVE AND TITLE	OF CERTIFIER	1		MA	1				ENSE NUM					fonth, Day, Year)
	P	30. NAME AND ADDRESS OF	PERSON WHI	O COMPLETED CAU	SE OF DEA	-				111	C.M.				-29-	-
		31. DATE FILEO (Month, Day, Y	bar)	32. REGISTRA	AR'S SIGNA	TUDE		enn	Str	eet	, Bá	alt	imore,	Ma	ryla	nd 21201
		MAR 3 1 19	93	fretie Davids	Son- As	ndell										

		216-10-211	19	1 💢 M 2 🗆 F	76	YRS.	MONT
pinous		9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b.
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	اقا	RESIDENCE OF DEC	10b. COUNT				
permit. Pages 1,	DIRECTOR	Maryland	100. COUNT	Baltin	2040	10c. Cl	TY, TO
ij.		100. STREET AND NUMBER		Butto	10/16		
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9 8 1	B	3 Widowed 4 Divo	rced	IF YES, GIVE V	WAH OH DATES		
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MARY retained to 5 should	2	Marie E. N				19b. MAILIN	
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OR G may stor, p		20g. METHOD OF DISPOSIT 1 Burlal 2 Crematic 4 Donation 5 Other	n 3 🗌 Ram	oval from State	cemetery, c	Crematory or	other pl
Page 6 m al director,		21. SIGNATURE OF FUNERA		CENSEE	- 1 Oak	Lawn	Ce
BALTIMORE, MARYLAND 21215-0020 er death. Page 6 may be retained by the honorill or strange physical functor, page 5 should be detached by the transition of the burner and transition of the saminer must be notified at once.	- 1	1000	0	Card	5)		
BA irs after di n by the f removal.		OO DART I Surrette d	Sq 1.	(3)(3)	~~		
Hours after d in by th or remove		23. PART I. Enter the d shock, or h		List only one cau			not e
24 how filled tion, or		iMMEDIATE CAUSE (Fir disease or condition	nai	-	~ ^ -		
760, ed within ompletely al, cremat event,		resulting in death)	→	a. Ould m	(OR AS A CONS	SECHIENCE (MC).
376 nted v comp rial, c	_		_		brova		
OX 68: te be execute sician and co orior to buria traumatic	<u>o</u>	Sequentially list condit if any, leading to imme			(OR AS A CONS		
SO)	S	cause. Enter UNDERLY	ING	. Reno	u Fa	iture	0
O. B ertificat ing phy vgiene p	Ē	CAUSE (Disease or Injuthat initiated events	c		(OR AS A CONS		P):
P.C	CERTIFICATION	resulting in death) LAS	T L	a Myor	cardio	21]	n
ETAL RECORDS, P.O. BOX 68760, The law requires that the death certificate be executed within 24 hours after tate has been signed by the attending physician and completely filled in by the tate Dept. of Health and Mental Hygiene prior to burial, cremation, or removal tem 23 shows eny injury, or other traumatic event, the medical		PART II. Other significa	int condition	s contributing to	deeth but no	t resulting	in the
ORI that the original parts	MEDICAL						
RECOR requires that been signed by of Health an	Ē						
AL RE he law requires been so bept. of h							
AL he law be has be Dept.	SICIAN:	25. WAS CASE REFERRED T	O MEDICAL				
- Sea	SIC	EXAMINER?		HOSPITAL:	ER/Outpatient	3 🗆 DOA	OT 4 □
ATTENDING PHYSICIAL CITOR: After this certific s after death with the 28 is marked, or	PHY	27. MANNER OF DEATH	. U. STOCK	28s. DATE OF (Month, D		29b. TII	WE OF
ON OI DING PHYS After this death with	BY	1 Netural 5 2 Accident	Pending Investigation				
ISIO TTENDIA Affor: Af affor de 28 Is I	ED		Could not be	28a. PLACE C building,	of INJURY — At etc. (Specify)	home, farm,	street
DIVISION OF OR ATTENDING PHYSIC DIRECTOR: After this ce hours after death with th item 28 is marked,	ш		determined		<u></u>		
DIV TAL OR / AL DIRE- 72 hours If Item	APL	one)		CIAN: To Iha best of			
	COMPL	2 MED	ICAL EXAMINE	R: On the beals of e	xamination and/	or investigati	lon, In
TO THE HOSPI TO THE FUNEF Se filed within	BE (296. SIGNATURE AND TITLE	OF CERTIFIE	P-	4.4		
100 de 10	2	110000	<u> </u>	du	NG	T-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	
		30. NAME AND ADDRESS O	PERSON WH	COMPLETED CALL	SE OF PEATHY	TEM 27) (TYP)	e Print,
				ILVVVII /		CALL I	The same

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH THY NAME (First, Middle, Last) 2. DATE OF DEATH Richard Henry McGee 0 ANDER 1 YEAR IF UNDER 24 HRS. COCIAL SECURITY MIMBER 7. DATE OF BIRTH BIRTHPLACE (State or Foreign (Month, Day, Year) 12-23-1916 HOURS DAYS Maryland CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Baltimore City WN OR LOCATION 10d. INSIDE CITY LIMITS? Dundalk 1 YES 2 XNO 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21222 United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-H was specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Ri White AL OCCUPATION fone during most of working red.) 16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel Corp. 18. MOTHER'S NAME (First, Middle, Melden Sumame) Margaret Clemson RESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) a Avenue Dundalk, Maryland 21222 POSITION (Name of 20c. LOCATION — City or Town, State OATE meteru 3/30/93 Baltimore, Maryland 22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. T922 Wise Avenue Dundalh Maryland
nter the mode of dying, such as cardiac or reepiratory errest, Ap Approximate Interval Between Onset and Death Accident farction 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO 1 YES 2 NO 26. PLACE OF OEATH (Check only one) HER: Nursing Home 5 - Residence 6 - Other (Specify) 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED 1 YES 2 NO factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) the lime, data and place, and due to the cause(s) and manner as stated. my opinion, death occured at the time, date and place, and due to the cause(s) end manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) ▶3 93 D21394 phynician en Med. 32. REGISTRAR'S SIGNATURE
Gulia Davidson Randale.



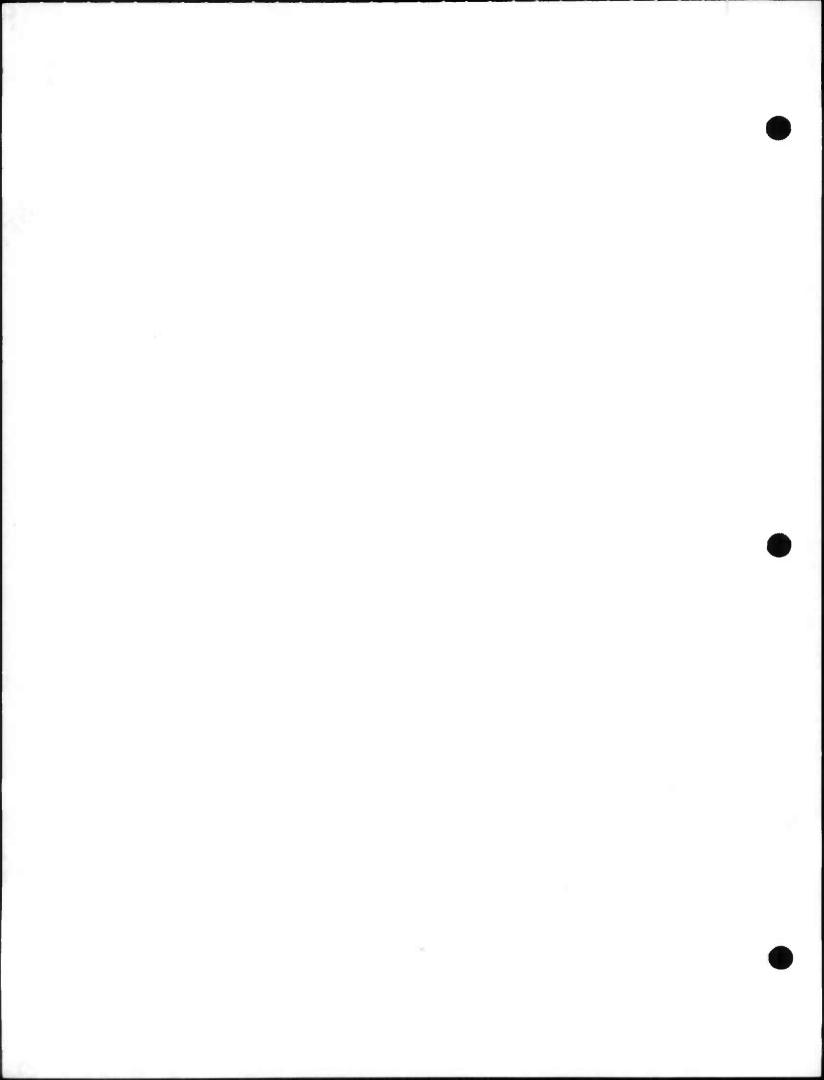
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE OF I	MARYLAN	ID / DEPAR CERTIF	TMENT (F HI	EALTH AND	MENTA	L HYGIEN	Ε	J	00000
	1. OECEOENT'S NAME (First, Middle, Last)				-			OF DEATH			3. TIME OF OEATH
	SOPHI	IA AN	N NOW	LIN			MONT 3	- 30-9	3	YEAR	11:30 Am
	4. SOCIAL SECURITY NUMBER 5. SEX	rs. last birthday)	IF UNDER 1 Y	_	IF UNDER 24 HRS.		OF BIRTH		S. BIRTH	IPLACE (State or Foreign	
	212-07-4260 1 M 2 M F	87 YRS.	MONTHS D	AY8	HOURS MIN.	3-23-1906			Maryland		
-	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF OEATH										EATH
DIRECTOR	Greater Baltimore Med	ical	Ctr.	٦	VO V	son			Ва	lti	more
EG	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR L	OCATE	ON					10d. INSIDE CITY
8	Maryland Baltimo	ore		.,			wsor	1			LIMITS?
	10e. STREET AND NUMBER				101.	ZIP CODE			10a CITI	ZEN OF V	1 ☐ YES 2 🔯 NO WHAT COUNTRY?
FUNERAL	111 West Road					2120	4		log. Gitt		JSA
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORI								N? (Specify Yes	or No.		
	1 Never Married 2 Merried FORCES? 1		If ye	a, spec	city Cuban, Maxica 2 XNO Specif	an, Puerto	Rican, etc.)		Speci	— American Indian, k, White, atc.	
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COMPLETED	15. OECEDENT'S EDUCATION (Specify only highest grade completed)	16	e. DECEOENT'S	work done durir	PATION of most	N t of working	161	. KINO OF BUS	INESS/IND	USTRY	
۳	Elementary/Secondary (0-12) College (1-4 or 5	+)	life. Do NOT us	te retired.)							
N N	4th		Sa.	lespe	rs				ler	S	
	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA			.,		
BE	Samuel Weitzel 190. INFORMANT'S NAME (Type/Print)							Cha1			
2	Stanley Merson					d Number or Rural Avenue					21 21 1
	20a. METHOD OF DISPOSITION			_				ltimo			21211
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	Baltimore National 4/2 Baltimore, Maryland Baltimore National 4/2 Baltimore, Maryland Burgee-Henss Funeral Home										
	> //ella desalin	-	-								
_	State And ay	enu	0			Falls					MD 21211
	23. PART I. Enter the diseases, or complications the	t caused the	e daath. Do r	ot antar the	mod	la of dying, auc	h aa can	diac or respi	ratory erro	est,	Approximata Interval Between
	IMMEDIATE CAUSE (Finel		. 1	-1							Onset and Death
	disease or condition resulting in death)	te res	ral fa	lune							7 Lays
	Jr. /	(UH AB A CO	NISEQUENCE OF	7:							1411.
CERTIFICATION	Sequentielly list conditions,	CLEMAN A CO	NSEQUENCE OF	n.							10 saya
¥	If any, leading to immediate cause. Enter UNDERLYING	0	tonis	+1	1	11-					10 16
Ĕ I	CAUSE (Disease or Injury that Initiated events	(DR AS A/CO	NSEQUENCE OF):	N	money-					10 2012
E	reaulting in death) LAST	()				Λ					1 1
	DATT II Oh	0				U					1 0
¥.	PART II. Other significant conditions contributing to	daath but i	not reculting	n the under	lying	ceuse given in	Part I.	24s, WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	- Almente							1 YES 2	™ NO		COMPLETION OF CAUSE OF CEATH?
¥	Mimatri arthitis										1 TYES 2 NO
PHYSICIAN: MEDICA											
ᅙ	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:			OTHER:	6. PLA	CE OF DEATH (Ch	eck only or	10)			
₹	t ☐ YES 2 19 NO 1 1 12 repetient 2 C 27. MANNESLOF DEATH 28s. DATE OF	-		4 - Mursing	-	5 - Residence	-				
	1 Natural 5 Panding 28s. DATE OF (Month, D		28b. TiM	URY	WOR	K7	28d. OES	CRIBE HOW IN	JURY OCC	UREO	
B	2 Accident Investigation 3 Suicide a Constant by 28e, PLACE O	F INJURY -	At home, ferm, a			IS 2 □ NO	201 100	ATION (Course			
	# Suicide 6 Could not be building.	etc. (Specify)	100000	THE INCOME.	O-Hille		City	ATION (Street a or Town, State)	na Number (or Humi H	loufe Number,
COMPLETED	29s. CERTIFIER	_	100		_		11				
₹∥	Check only CERTIFYING PHYSICIAN: To the best of	my knowledg	e, death occurre	d at the time,	data a	nd place, and dua	to the cau	ise(a) and men	ner aa state	d.	
8	MEDICAL/EXPLINER: On the basis of as	amination an	d/or investigatio	n, in my opini	on, dea	ith occured at the	time, date	and place, and	due to the	ceuse(a	and menner as stated.
BE	296. SIGNATURE (NO VITLE OF CENTIFIER					29c. LICENSE NUM	-				(Month, Day, Year)
٥	30 NAME AND ARREST OF BERSON WILL COMPLETE	E OF DE	######################################	21.0		D-149	13/		- 3	-36	7-93,
	30. NAME AND ANDRESS OF PERSON WHO COMPLETED CAUS				h-	wn Dan	1======				
	Dr. Smith 31. DATE FILED (Month, Day, Year) 32. REGISTRA			Nort	пe	rn Par	ĸwa]	<u> </u>			
	31. DATE FILED Mydith, Day, Year) 32. REGISTRA MAR 3 1 1993	Cont - Aller	A. S.								



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

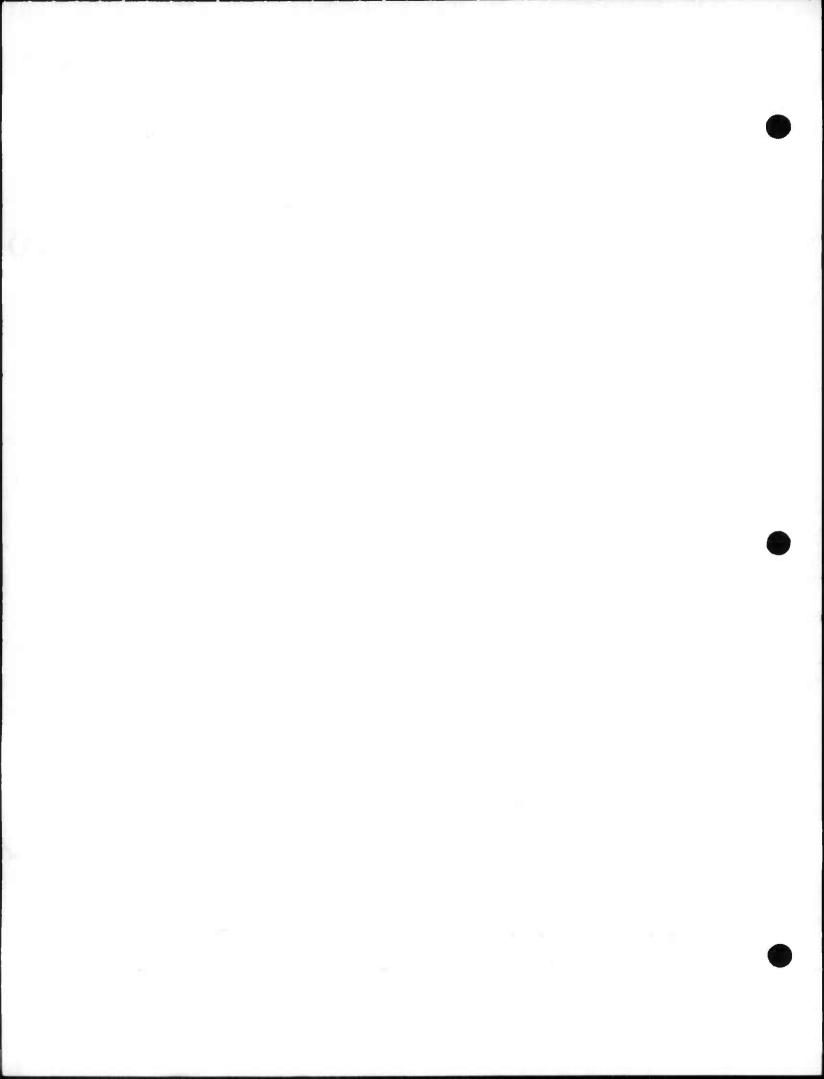
AMENDING PHYSICIAN: The law requires that the death certificate be executed within

liver 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS M 2 DF 215-64-9663 35 12-2-57 use as the burlal-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR UNIVERSITY HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD BALTIMORE XX YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1111 ORLEANS STREET 21202 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician, 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S., ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indien, Black, White, etc. XIX Never Married 2 Merried If yes, specify Cuben, Mexican, Pr 1 TES 2 NO ВҰ Specify: Specify 3 Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INDUSTRY ō Elementary/Secondary (0-12) College (1-4 or 5+) 12th by the funeral director, page 5 should be detached removal. LABORER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) F CLEMENT OLIVER EVELYN BURT notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 EVELYN OLIVER 1111 ORLEANS ST./BALTIMORE, MD 21202 be 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must DATE MD NAT MEM. PARK LAUREL, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVE. RMand medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heert failure. Let only one cause on each line. filled in by Approximate interval Between IMMEDIATE CAUSE (Fine) Onset and Death the disease or condition been signed by the attending physician and completely in to Health and Mental Hygiene prior to burial, cremation shows any injury, or other traumatic event, the Sefsis resulting in death) Apric in a phi DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially ilst conditions, if any, leading to immediate cause. Enter UNDERLYING old Mi [rul negurari Tuficas CAUSE (Disease or Injury that initiated events status epilepticu. resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE YES 2 NO OF DEATH? 1 - YES 2/2 NO Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? DIRECTOR: After this certificate he hours after death with the State Ditem 28 Is marked, or item 28. PLACE OF DEATH (Check only one) 1 VES 2 NO OTHER: Inpatient 2 - ER/Outpatient 3 - DOA ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED | PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) Natural 5 Pending Investigation BY 1 YES 2 NO 2 Accident COMPLETED 3 Suicide 8 Could not be 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. CERTIFIER Check only Check only PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and menner ee stated. TO THE FUNERAL C be filed within 72 h IMPORTANT: If It 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day. Sartarazi 223 2 S. Green Sineer Univ of

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

2. DATE OF DEATH

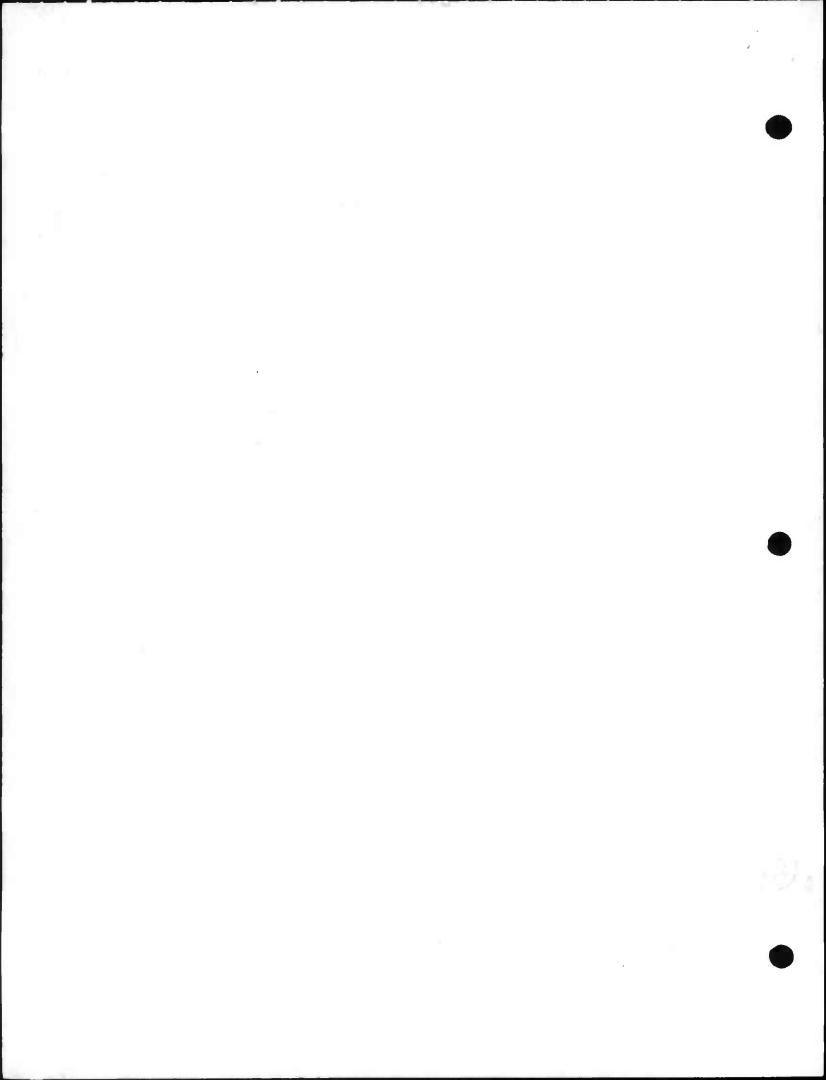


BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VILAL RECORDS, P.O. BOX 68/60	THE OR ATTENDING PHYSICIAN: The law requires that the death certificate he executed within 24 hours
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TENDING PRINCIPLY IN THE LAW REQUIRES THAT THE DESTRICTION OF THE SECURED WITHIN 24 HOURS ATTENDED BY THE POSPITAL OF ATTENDING PRINCIPLY.	EMECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunjat-transit permit. Pages 1 2 3 should	72 hours after death v	Harm 28 is mark
Contract of the	TH CHARK	fled within 72	POSTANT: 14

	1 - STATE OF MARYLAN	ID / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.	3 08641						
4		ens	2. DATE OF DEATH MONTH O.3 -29 - 9	3. TIME OF DEATH 3. TIME OF DEATH 3. TIME OF DEATH						
	215 05 8518 1× M2 0 F 7	YRS. WONTHS DAYS HOURS MIN.	12-21-16	BIRTHPLACE (State or Foreign Country)						
TOR	98. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice RESIDENCE OF DECEDENT	Towson M		Baltimore						
DIRECTOR	MARYLAND 10b. COUNTY	10c. CITY TOWN OR LOCATION BATTIMORE	0,74	10d. INSIDE CITY LIMITS? 1 PYES 2 NO						
FUNERAL	1802 HILLENWOOD X	POAD 101. ZIP CODE 2/2.	39 10g. CITIZE	N OF WHAT COUNTRY?						
В	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATE	2 NO If yes, specify Cuban, Mexi-	can, Puerto Rican, etc.)	RACE — American Indian, Black, White, atc. Specify:						
COMPLETED	15. DECEOENT'S EDUCATION (Specify only highest grade completed) 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY									
OMP	17. FATHER'S NAME (First, Middle, Last)	DENTAL LAB. C	PERATOR							
BE C	JOSEPH OWENS	HEL		DWENS'						
5	FAMILY RECORDS	19b. MAJLING ADORESS (Street and Number or Rural SAME AS	AROUTE Number, City or Town, State Zip C	ode)						
	20e. METHOD OF DISPOSITION 1 Burial 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of confliction) City or Town, State 4 Donation 5 Other (Specify) Confliction (Specify) Conflict									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF F	ACILITY WISHER OF PHAN	5 61						
	23. PART I. Enter the disease, or complications that caused the	e deeth. Do not enter the mode of dying, su	ch es cerdisc or reepiratory arres	t, Approximate						
	shock, or heert fellure. List only one cause on each immediate Cause (Final disease or condition resulting in death)	plastona		interval Between Onset and Death						
z	DUE TO (OR AS A CO	INSEQUENCE OF):								
ATIO	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING	INSEQUENCE OF):								
CERTIFICATION	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CO resulting in death) LAST	INSEQUENCE OF):								
11	PART II. Other significent conditions contributing to deeth but i									
MEDICAL	- State - Stat	not resulting in the Underlying cause given in	1 Part I. 24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE DE DEATHS						
: ME				DF DEATH? 1 YES 2 AO						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF OEATH (C	heck only one)							
14SI	1 VES 2 NO 1 Inpetion 2 ER/Outpetle 27. MANNER OF DEATH 28e. DATE OF INJURY			rice						
ВУ Р	1 Naturel 5 Pending (Month, Day, Year) 2 Accident Investigation	28b. TIME OF 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCOU	RED						
		At home, farm, street, factory, office	281. LOCATION (Street and Number or City or Town, State)	Rural Route Number,						
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledg									
	29b. SIGNATURE AND TITLE OFFICERTURIER	29c. LICENSE NU		Suse(e) and manner se stated.						
TO BE	Calla H alleyand	40 027	087 10	3 29 93						
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH CARLA S. ALEXAND	En Stella M	aris Hospic							
	31. DMAR 31 1993 Julia Maria Salaman	BLEE.								

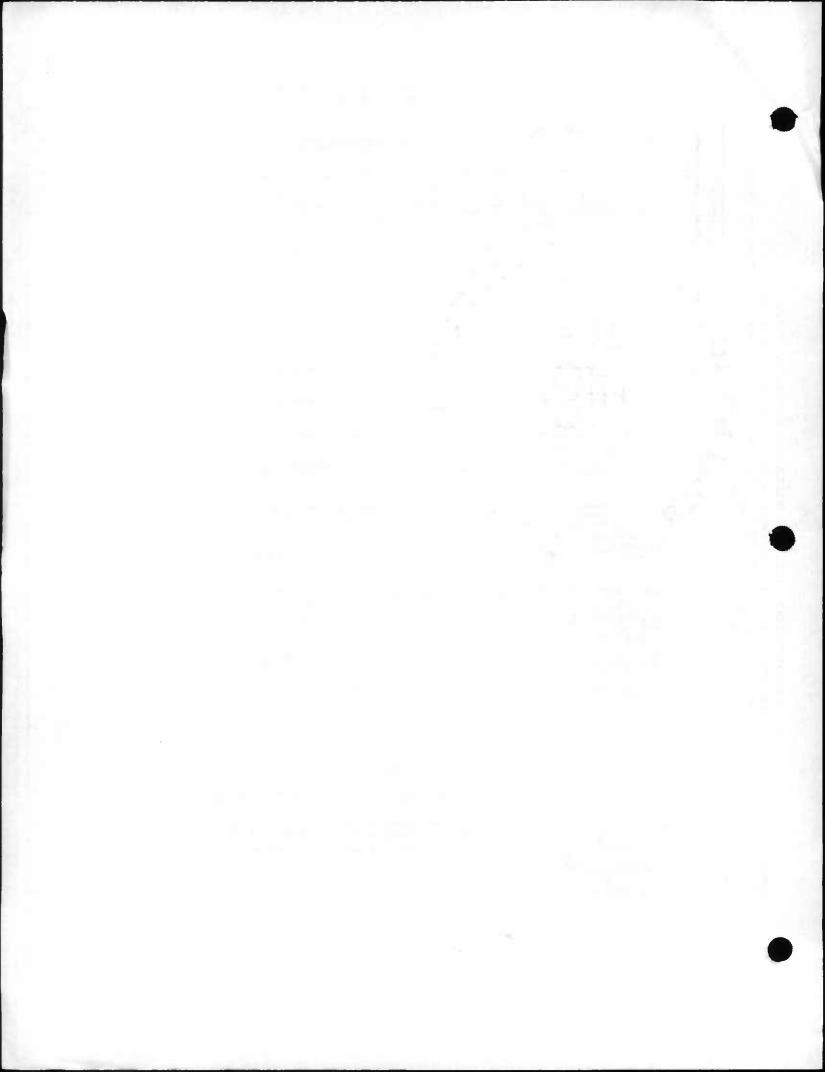


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NDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi	: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	
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	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		MENT OF H		IENTAL HYGIEN		08642
	1. OECEDENT'S NAME (First, Middle, Last) WARNE	R POWE	Ell	J. (1)		2. DATE OF DEATH MONTH D.		3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 092-07-5430	5. SEX 6. AGE (In yrs	-	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 03-29-	12 0	BIRTHPLACE (State or Foreign- country) RGTNTA
TOR	9a. FACILITY NAME (If not institution, give str OSE PH RICH RESIDENCE OF DECEDENT	HEY HOSPIC			MURE,		9c. COUNTY	OF DEATH
DIRECTOR	10e. STATE 10b. COUNTY MARYLAND			TOWN OR LOCATE BALTIM			-	10d. INSIDE CITY LIMITS? YES 2 \(\text{NO} \) NO
FUNERAL	3523 GELSTON D	RIVE		101.	21229		10g. CITIZEN	OF WHAT COUNTRY? USA
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 JIF YES, GIVE WAR OR DATES	ARMED		city Cuben, Mexican		25-018	RACE — American Indian, Black, White, etc. Specify: Black
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)		DECEDENT'S US (Give kind of wor life. Do NOT use	SUAL OCCUPATION rk done during most retired.)	Y t of working	16b. KIND OF BU	SINESS/INDUST	RY
BE COM	17. FATHER'S NAME (First, Middle, Last) William H. Pow	ell			Hatti	e F. Fir	nney	
5	19e. INFORMANT'S NAME (Type/Print) Alfred Powell		3523	Gelsto	n Drive	oute Number, City or Tow Baltin		
-0	20e. METHOD OF DISPOSITION 1 XBurlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	val from State cemetery			al Park	Arl	cation — city Dutus,	or Town, State Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE			O. DYE LIBERTY			RAL HOME UE 21207
	23. PART i. Enter the diseases, or conshock, or heart failure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death)	omplications that caused the lat only one cause on each if	ine. Papie (1		as cardiac or respi		Approximata interval Betwee Onset and Dea
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CON						
CERTI	resulting in death) LAST							
MEDICAL	PART II. Other eignificant conditions	contributing to death but no	ot resulting in	the undariying	cause given in P	Part I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:		HOSPITAL: 1 Inpatient 2 ER/Outpetient		THER:	CE OF DEATH (Chec			
ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c. INJU WOR	RY AT	28d. DESCRIBE HOW I	NJURY OCCURE	D
	3 Suicide 6 Could not be determined	28s. PLACE OF INJURY — At building, stc. (Specify)	home, farm, stre	et, factory, office		28t. LOCATION (Street & City or Town, State)	and Number or R	ural Route Number,
COMPLETE		AN: To the best of my knowledge, On the basis of examination end						use(a) end menner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUME		29d. DATE SIG	

ha Beridon

8 1 1993



this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IB PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. inked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OF TO THE FUNERAL DEFE DE filed within 72 IMPORTANT: If III

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

MAR 3 1

30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1993

111

BAR'S SIGNATURE

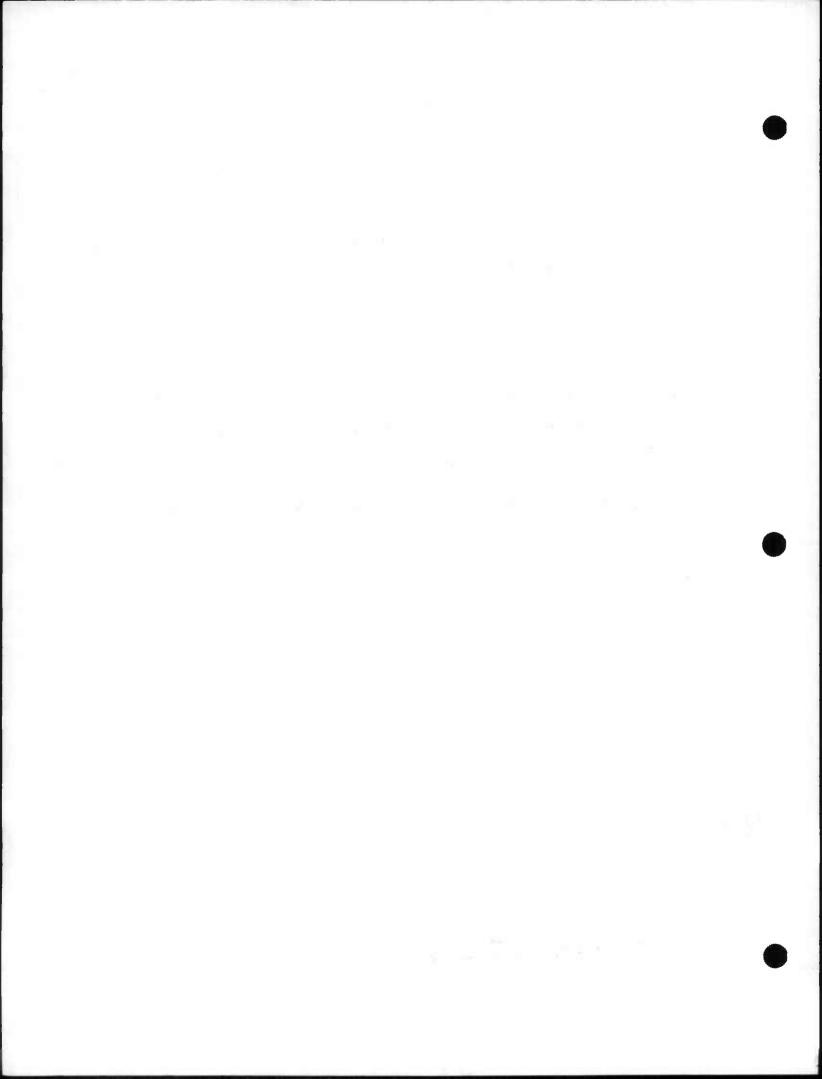
Penn Street, Baltimore, Maryland

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY FUNERAL DIRECTOR

ITEMS: 23	PART I,	11. 27.	. 28a	-f. PFR	MEO G-69	8 4/9/93	_				
FOR t.t						MENTAL HYGIEN	_E 9	13 (18643		
REGISTRAR		C	ERTIF	CATE OF	DEATH	REG. NO					
1. DECEOENT'S NAME (First, Middle, Last)	(SHELIA	()				2. DATE OF DEATH		3	TIME OF DEATH		
SHEILA D.			PARKEI			3 2	5 1	993	4:04 P M		
4. SOCIAL SECURITY NUMBER	5. SEX 6.	6. AGE (In yrs. last birthday		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPL	ACE (State or Foreign		
220-64-0349	1 🗌 M 2 💢 F	36 1		MONTHS DAYS	HOURS MIN.	7-22-5	6	Country) MD			
9a. FACILITY NAME (If not Institution, give si	9b. CITY, TOWN	OR LOCATION OF DE		_	NTY OF DEA						
SHOCK TRAUM	TINU A		BA	LTIMORE	CITY						
RESIDENCE OF DECEDENT											
10a. STATE 10b. COUNTY			-0	TOWN OR LOCAL				10	Dd. INSIDE CITY		
			BA	LTIMOR			1	X YES 2 NO			
104									AT COUNTRY?		
	126 EXETER STREET					21202 U.S.A.					
11. MARITAL STATUS 1 X Never Married 2 Married	12. WAS DECEDENT E FORCES? 1	YES 12 TY	RMED NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerlo Rican, atc.) 14. RACE — American to Black, White, atc.							
3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES 22	•		2 NO Specifi		i	Specify:	•		
15. DECEDENT'S EDUC	ATION	160.06	CEDENT'S	JSUAL OCCUPATION	M	400 2000 00 000	<u> </u>		ACK		
(Specify only highest grade Elementary/Secondary (0-12)	completed)	(G	ive kind of w	ork done durina mo	st of working	16b. KIND OF BUS	SINESS/INE	DUSTRY			
10th	College (1-4 or 5+)		CLER	K							
17. FATHER'S NAME (First, Middle, Last)					18 MOTHER'S NA	ME (First, Middle, Malden	Sumamal				
RAYMOND PARKER						LINE BRA	,				
19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								Code			
MADELINE DAVIS						LTIMORE,			2		
20a. METHOD OF DISPOSITION		1									
130 Burlet 2 Cremetton 3 C Removal from State								1000			
21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	IMEST	CKW		O ADDRESS OF FA		TUNS	VILL	E, MD		
Barry	20%										
Deman L	JOIW.	נימנ		WM.C	.MARCH	F.H./110	lΕ.	NOR	TH AVE.		
23. PART I. Enter the diseases, or c ahock, or heart failure. I	omplications that c ist only one cause	eused the de	eth. Do n	ot enter the mo	de of dying, suc	h aa cardiac or reapl	ratory arr	reat,	Approximate interval Between		
IMMEDIATE CAUSE (Finel									Onset and Death		
disease or condition resulting in death)	SUBDURA										
	DUE TO (OF	R AS A CONSE	OUENCE OF):							
Sequentially list conditions,											
If any, leading to immediate cause. Enter UNDERLYING	OUE TO (OF	AS A CONSE	OUENCE OF):							
CAUSE (Disease or Injury		AS A CONSE	OHENCE OF								
that Initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST											
PART II. Other eignificant condition	contributing to de	eth but not r	reaulting in	tha underlying	ceuse given in	Pert I. 24a. WAS AN			ERE AUTOPSY FINDINGS		
CHRONIC DRUG ABI	JSE_					PERFOR		CC	MILABLE PRIOR TO IMPLETION OF CAUSE		
									OF DEATH? 1 X YES 2 □ NO		
						_			G 125 1 10 110		
25. WAS CASE REFERRED TO MEDICAL				26. PL	ACE OF DEATH (Che	eck only one)					
EXAMINER? 1 X YES 2 NO	HOSPITAL:	R/Outpatient 3		OTHER:		6 C Other (Specify)					
27. MANNER OF DEATH	28e. DATE OF IN.	JURY	286 TIME	OF 28c. INJ	URY AT	28d. DESCRIBE HOW II	NJURY OCC	CUREO			
1 Netural 5 Panding 2 Accident Investigation	Found: 3-		OINGO		RK? 'ES 2 X NO	IINKNOMN					
3 Suicide 8 Could not be	reet, factory, office	Hice 281 I OCATION (Street and Number or Purel Pouls Number									
4 Homicide Homicid									ter Street		
290. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my	knowledge, de	ath occurred	s at the time, date		to the cause(s) and man					
						time, date and place, an			nd manner ea stated.		
29b. SIGNATURE AND TITLE OF CERTIFIER	2 21				29c. LICENSE NUM				orith, Day, Year)		
hlermin	0 0/	1			OCM		▶3	2			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by many TO THE FUNERAL DISCRETE Are: the certificate his been signed by the attention physician and completely filled in by the funeral director, page 5 should be filed within 72.

WHOORTANT: If the many the marked or law 23 shows any injury, or other traumatic event, the medical examiner must be notified at one

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21275-0

transit permit. Pages 1, 2, 3 should

		FOR 1 - STATE REGISTRAR	STATE OF MARYL		DEPARTME ERTIFICA			MENTAL	HYGIEN REG. NO	lE .	93	0861	بال
		1. DECEDENT'S NAME (First, Middle, Last) BABY GIRL RYNKI	EWICZ BAB		ICHELLE	NKIEV		2. DATE OF MONTH	F DEATH	**1993	YEAR	3. TIME OF DEATH 12:45 A.	
		4. SOCIAL SECURITY NUMBER NONE	1 🗆 M 2 💢 F	(in yrs. les	YRS. IF UN	DER 1 YEAR 6 DAYS	IF UNDER 24 HRS. HOURS MIN. 1 45	7. DATE OF	Day, Year)	1993	Country	PLACE (State or Fore	ign
TOR		98. FACILITY NAME (If not institution, give s THE JOHNS HOPKINS RESIDENCE OF DECEMENT		96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY					BALTIMORE CITY				
DIRECTOR		Maryland How		10c. CITY, TOWN OR LOCATION Ellicott City					10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL		9710 Starling R	101. ZIP CODE 21042					U.S.A.					
8		11. MARITAL STATUS 1 (X) Never Married 2 Married 3 Widowed 4 Divorced	N U.S. AR	RMEO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:					s or No—	14. RACE — American Indian, Black, White, etc. Specify: White			
COMPLETED		15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	(Gi	Do NOT use retire	ne during m d.)	during most of working							
NO N		17. FATHER'S NAME (First, Middle, Last)			ependen ⁻	L	18. MOTHER'S NA	MF (Fleet Mic	irile Mairier	Sumamal	_		
BE C					10.			18. MOTHER'S NAME (First, Middle, Maiden Sur Dorette			Mensing		
TO B	ĺ	19a. INFORMANT'S NAME (Typer/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								riig	\neg		
	Mr. John Rynkiewicz Same as #10												
20a. METHOD OF DISPOSITION 1 (X) Burlial 2 Cremation 3 Removal from Stats 4 Donation 5 Other (Specify) 20b. PLACEAND DATE OF OISPOSITION (Name of cemetery, crematory or other place) St. Mary S 4/2/93 Hand								nover	on - city or Town, State Ver Twp., Penn.				
		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE Paul Ly H	artso	ck,Jr.	2, NAME A	ND ADDRESS OF FA	ксішту В	altin	nore,	MD 2	21214	
		Haul I Ha	utorch y			Leo	nard J. F	Ruck,I	nc.	5305	Hart	ord Rd.	
165		23. PART I. Enter the diseases, or o shock, or heart failure.	complications that cause List only one cause on e	d the de	ath. Do not en	er the m	ode of dying, suc	ch as cardia	c or resp	iratory arr	est,	Approximate interval Bet	
	1	IMMEDIATE CAUSE (Final disease or condition	155000		00 15	4						Onset and I	
		resulting in death)	1 I U	VIENCE OF	4						MW	VIE	
_			DOE TO (ON AS	TO (OR AS A CONSEQUENCE OF):									
RTIFICATION		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEC	DUENCE OF):	-						 	
ERTIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST												
MEDICAL CE		PART II. Other significant condition	s contributing to death t	out not n	esulting in the	underlyir	ig cause given in		4a. WAS AN	RMED?	24b.	WERE AUTOPSY FINE MAILABLE PRIOR TO COMPLETION OF CAI	
N. MEC	1 YES 2 NO OF DEATH? 1 YES 2									OF DEATH?	,		
CA		EXAMINER? HOSPITAL: OTHER:						eck only one)			-		
PHYSICIAN		1 YES 2 JOO 27. MANNEB OF DEATH	1 Inpatient 2 ☐ ER/Out		Nursing Home 5 Residence 6 Officer (Specify) CUV GV KOO 1					Koom			
ВУ Р							200. OLGONIOL HOW INJUNT OCCUPED						
P		3 Suicide 6 Could not be determined	ide 6 Could not be 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							and Number	or Aural A	oute Number,	
COMPLE		29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(s) and manner as stated.											
BE COI		296. SIGNATURE AND TITLE OF CERTIFIER		er sna/or l	investigation, in m	y opinion,	death occured at the		nd place, ar			(Month, Day, Year)	led.
10		30. NAME AND ADDRESS OF RERBON WHO	O COMPLETED CAUSE OF DE	ATH (ITE	27) (Type Print)					3	125	193	

DHMH-16 Flev 1/89

E ANO ADDRESS OF

31. DATE FILEO (Month, Day, Year)
MAR 3 1 1993

32. REGISTRAR'S SIGNATURE Julia Davidson-Randall

10- 25-6P 001

BALTIMORE, MARYLAND 21215-0020

should

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

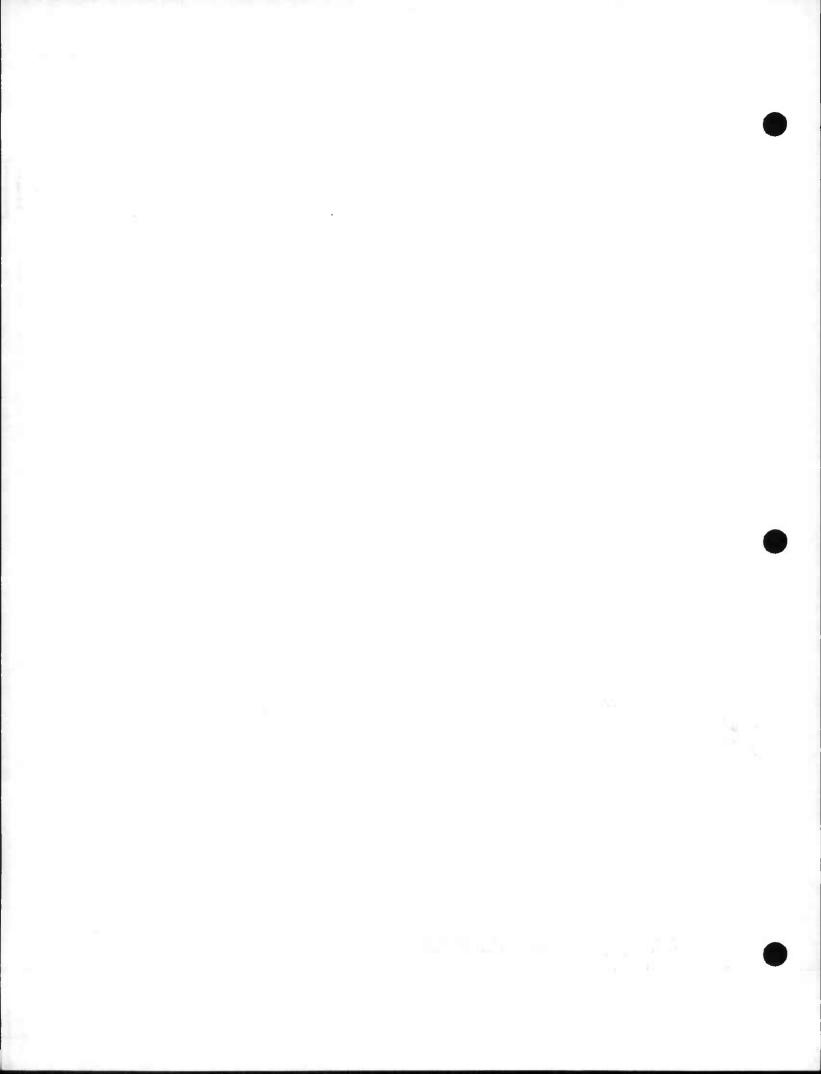
The stain is the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	and the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buria-transit pernet. Pages 1.2.3	The ith and Mental Hygiene prior to burial, cremation, or removal.	sections any Injury, or other traumatic event, the medical examiner must be notified at once.
西湖	tiffegte	e Stille	r ite
PHYSIC	this cer	with th	irked, t
NDING	R: After	er death	is ma
JR ATTE	IRECTO	ours afte	ВШ 28
PITAL C	ERAL D	in 72 hc	THE
TO THE HOSPITAL OR ATTENDIN	TO THE FUNERAL DIRECTOR:	be filed within 72 hours after de	IMPORTANT: If Item 28 is m
10	10 1	be file	IMPC

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 1. TIME OF DEATH Rodg Mary Robert 0850 Am 03 IF UNDER 1 YEAR 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year 6. AGE (In yrs. last birthde IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 220-60-8220 1 - M 2 X F 4 04 9a. FACILITY NAME (If not institution, give 9c. COUNTY OF DEATH St Agn FUNERAL DIRECTOR Baltimore 10a. STATE 10b. COUNTY 19c. CITY-TOWN OR LOCATION 10d. INSIDE CITY atons UIII 1 YES 2 NO 10e. STREET AND NUMBER 10f, ZIP CODE WHAT COUNTRY? 21228 U ·5.A 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 UPS 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO FORCES? 1 YES 2 1 Never Married 2 Married BY 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 66. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) Teacher BA Degre 17. FATHER'S NAME (First, Middle, Last) gers BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Nur 2 Roa 01 21228 20a, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 4/2/93 20c. LOCATION City or To 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUTERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY

March F/H West 4300 Wabash Avenue 23. PART i. Enter the disessea, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, Approximate ahock, or heert failure. List only one cause on eech line. Interval Betwe IMMEDIATE CAUSE (Fine) Onset and Death avoluce disesse or condition resulting in death) PHYSICIAN: MEDICAL CERTIFICATION Sequentielly list conditions, DUE TO JOR AS A CONSE if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 | YES 2 | NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA se 5 🗆 Residence 6 🗆 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Natural 1 YES 2 ND ВҰ 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be datarmined COMPLETED 4 Homicide 29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) BE 28/93 Render redice 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MUTOMBO KONDO MAG

32 STGISTRAR'S SIGNATURE

MAR 34 1983



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH 3. TIME OF DEATH 93 DAY 6. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month), Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS /1 □ M 2 X F DAYS funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ER 0 Ballo RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY ALT 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 5 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 14. RACE — American Indian, Black. White, etc. If yea, specify Cuban, Mexican, P.

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 ₩ Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
'Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 165 KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) OUSEWIFE 17. FATHER'S NAME (First, Middle, Last) 18_MOTHER'S NAME (First, Middle, Malden Surname) QNION BE notified 19a. INFORMANT'S NAME (Type/Print) 2 1 be 20e. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must 3/3/ 4 Donation 5 Other (Specify) menty examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. MAME AND ADDRESS OF FACILITY Joseph 0 EN/RA completely filled in by the rial, cremation, or removal. medical 23. PART1. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 traumatic event, the disease or condition Diabetes resulting in death) OUE TO (OR AS A CONSEQUENCE OF) signed by the attending physician and con Health and Mental Hygiene prior to burial, cereby CERTIFICATION Sequentially list conditions, if any, leading to immediate QUE TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING CAUSE (Disease or Injury Injury, or other OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other algnificant conditions contributing to death but not reaulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO this certificate has been with the State Dept. of h PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: stlent 2 - ER/Outpatient 3 - DOA 4 I Nursing Home 5 Residence 6 Other (Specify) 10 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED marked, Natural
Accident 5 Pending 1 YES 2 NO BY O THE HOSPITAL UNITED ARE TO THE FUNERAL CHEEK ARE TO THE GROWN AS A SHORT THE GROUN AS TO THE CHEEK TO BE TO THE CHEEK TO BE TO THE CHEEK TO BE TO THE CHEEK TO BE TO THE CHEEK TO BE TO THE CHEEK TO THE THE CHEEK TO THE T After death 3 Suicide 28s. PLACE OF INJURY — At home, farm, streat, factory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined BE COMPLETED 4 Homleide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPING TO THE FUNERA Do filed within A D 28998 29b. SIGNATURE AND TITLE OF CERTIFIER ≥ 3 -29-93 ntam 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (TYPO, PTINT)

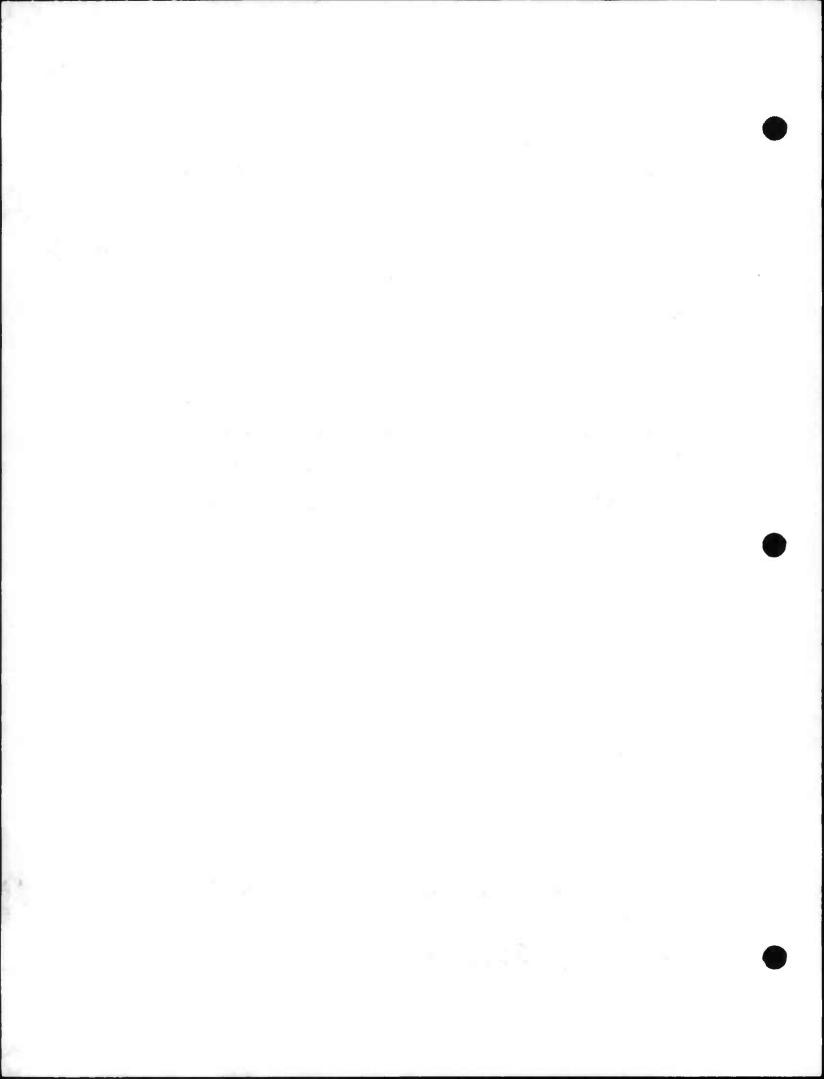
PRITAM S. SAINI MD 9101 CHERRY LN # 211 LAUREL MD

MD

31. DATE FILED (Month, Day, Year)

1993

12 BEGISTRAR'S SIGNATURE



page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

director,

completely filled in by the funeral rial, cremation, or removal.

Hygiene prior to burial,

After this certificate has been signed by the attending physician death with the State Dept. of Health and Mental Hygiene prior to

FUNERAL DIRECTOR: within 72 hours after

THE THE

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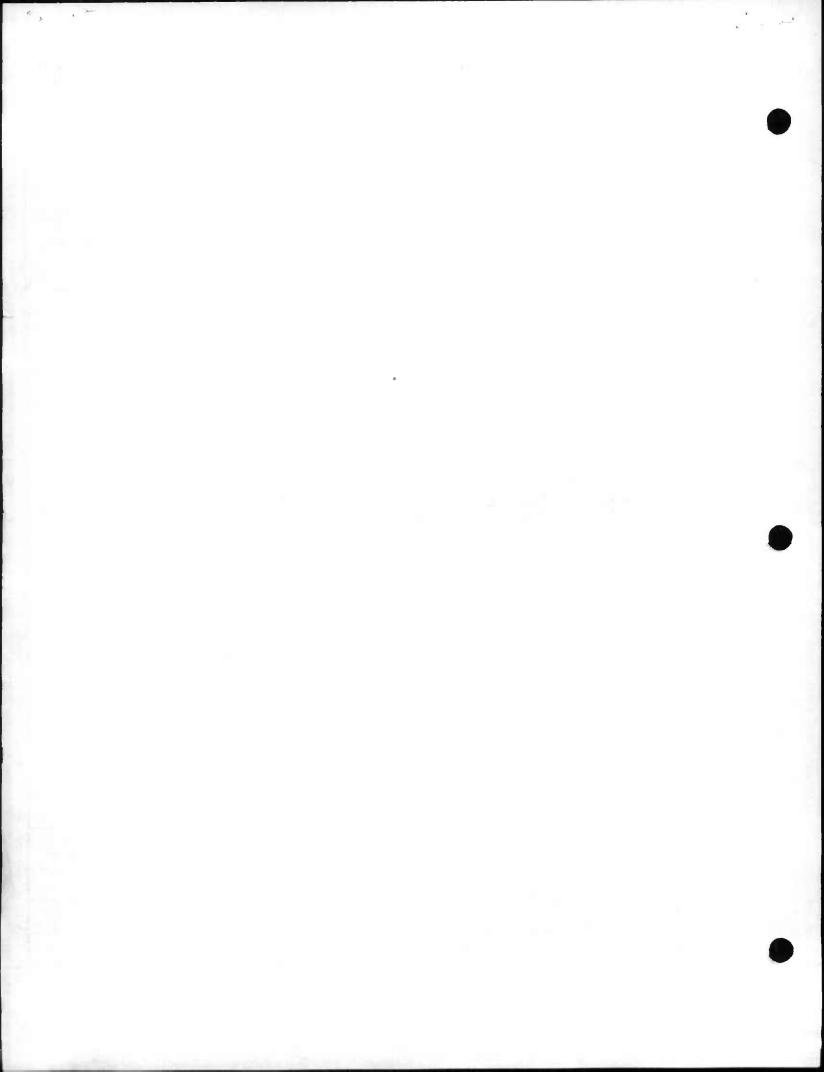
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) BABY GIRL 2. DATE OF DEATH 3. TIME OF DEATH

3:03PM ROBESON 64 on 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAVE 1 M 2 F 3 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATH levey Hos DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 TES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? Good now Rd -12. WAS DECEDENT EVER IN U.S. ARMED 21206 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexicen, Puerto Ricen, stc.) 14. RACE — American Indian, Black, White, etc. FORCES? ORCES? 1 YES 2
YES, GIVE WAR OR DATES 2 NO 1 Never Merried 2 Married BY 1 YES 2 NO Specify: 3 Widowed 4 Olvorced ack COMPLETED 15. DECEDENT'S EDUCATION 18a. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compl Elementary/Secondary (0-12) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Kevin Hobeson notified at BE Terina 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 4911 Goodnow Road Baltimore, MD 21206 Terina Robeson 99 20a. METHOD OF DISPOSITION must 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE 1 □ Burial 2 □ Cremation 3 □ Removal from State
4 ☑ Donation 5 □ Other (Specify) the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ronald Wade, Dir State Anatomy Board 3/25/93 655W.Baltimore St,Balto,MD 21201 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or haart failure. List only one cause on each line. Interval Between MMEDIATE CAUSE (Final Onaet and Death disease or condition Prematurity swere LIFE reaulting in death) or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 23 shows any Injury, PART il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 70 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Pinpetient 2 ER/Outpetient 3 00A OTHER: 1 YES 2 10 4 Nursing Home 5 Realdence 8 Other (Specify) 6 28a. OATE OF INJURY (Month, Day, Year) 27. MANNER OF OEATH 28b. TIME OF INJURY marked, 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO 1 Natural 5 Pending M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) -99 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be item 28 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. IMPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piacs, and due to the cause(s) end menner as stated. BE R. L. GUTBERCET 294. LICENSE NUMBER 29d. OATE SIGNED (Month, Day, Year) na D035 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, 52. RECUSTRAIN'S SIGNATURE



REG. NO

2. DATE OF DEATH

FOR STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Last)

Koyster

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6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year DAYS HOURS 1 M 2 KF 12/11 228-07-5660 YRS /1917 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF CEATI DIRECTOR HAYES NURSING HOME BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE burial-transit permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 1117 Forrest Street 21202 nurs after death. Page 6 may be retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married
3 Wildowed 4 Divorced 2 00 BY IF YES, GIVE WAR OR DATES detached for use as the COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) drector, page 5 should be notified at Charlie Oliver Freely 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Oliver Royster Forrest St. Baltimore, pe 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must Arbutus Memorial Park Arbutus, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE the attending physician and completaly filled in by the Merital Hyglene prior to burst, cramation, or removal. medical 23. PARTEL Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest sflock, or heart fallu e. List only one cause on each line. IMMEDIATE CAUSE (Final 曹 disease or condition within resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF). executed alonale traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING pertens the death certificate be other CAUSE (Disease or Injury DUE TO (QR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 FUNERAL DIRECTOR: After this certificate has been signed by the atter within 72 hours after death with the State Dept. of Health and Mental is TANT: If item 28 is marked, or Item 23 shows any Injury, or PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO PHYSICIAN: MP 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: DR ATTENDING PHYSICIAN; 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ne 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) ETED | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be 4 Homicide 29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. COMPL HOSPITAL IMPORTANT: 18 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 出 표를 Upelou 96 23 9 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) LIBERO 38 FALLS 2121 34 RD 31. DATE FILED (Month, Day, Year) 1 1993

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS.

nake

3. TIME OF DEATH

VIRGINIA

10d. INSIDE CITY LIMITS?

1 XYES 2 | NO

- American Indian, White, stc.

Black

Approximata

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

9

Interval Between Onset and Death

YEAR

9c. COUNTY OF DEATH

10g. CITIZEN OF WHAT COUNTRY?

MD 21202

14. RACE Black

USA

DHMH-16 Rev 1/89

TO BE COMPLETED BY FUNERAL DIRECTOR

spirit and and physician.

BALTIMORE, MARYLAND 21245-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ours after death. Page 6 may be retained by the hear	d in by the funeral director, page 5 should be detached or removal.	medical examiner must be notified at once.	TO BE COME
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hear	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

ATTANASIO

32. REGISTRAR'S SIGNATURE
Julia Davidson Mandalla

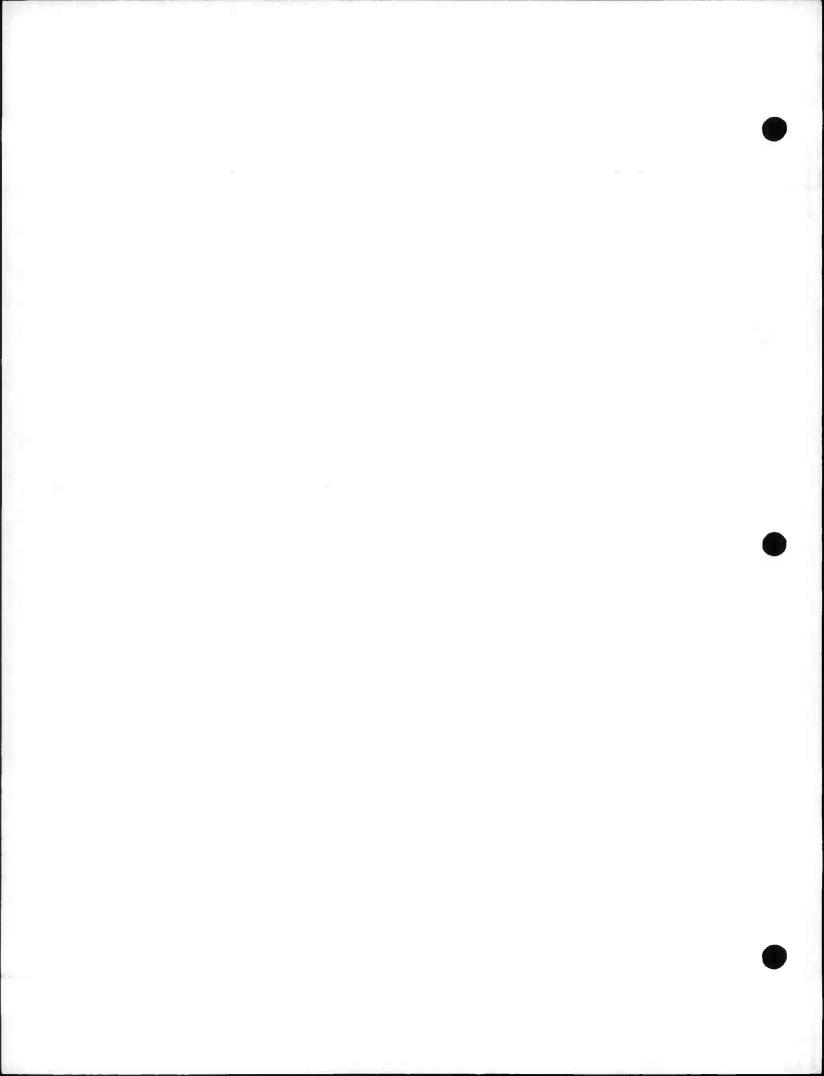
31. DATE FILED (Month, Day, Year)
MAR 3 1 1993

						9:	3 08649	
1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART CERTIFIC				E	- 00013	
1. DECEDENT'S NAME (First, Middle, Last)		CERTIFIC	DATE OF	DEATH	REG. NO.		3. TIME OF DEATH	
Elizabeth	Anna RUD	ACILLE			MONTH DA		EAR	
4. SOCIAL SECURITY NUMBER	1 (1) (1) (1)		F UNDER 1 YEAR	IF UNDER 24 HRS.	03 27	7 199	3 9:00 A. M BIRTHPLACE (State or Foreign	
218-18-0471	1 M 2 X F 8	2 YRS.	IONTHS DAYS	HOURS MIN.	(Month, Day, Year)		Country)	
9a. FACILITY NAME (If not institution, give st	reet and number)		Pb. CITY. TOWN C	R LOCATION OF DE	8-29-191		Maryland Y OF DEATH	
Franklin Square				sville	~		imore County	
10e. STATE 10b. COUNTY Maryland		10c. CITY,	TOWN OR LOCAT	Edge	mere		10d. INSIDE CITY LIMITS?	
10e. STREET AND NUMBER			104	ZIP CODE		40- CITIZE	1 ☐ YES 2 ☑ NO N OF WHAT COUNTRY?	
2610 North Snyd				21219		Un	ited States	
11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED			IC ORIGIN? (Specify Yes	or No- 14	I. RACE — American Indian, Black, White, etc.	
3 X Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES		2 NO Specify			Specify:	
15. DECEDENT'S EDUC	PATION	44 - 05050505050			T	- 1	White	
(Specify only highest grade	completed)	(Give kind of wo	rk done during mo:	n st of working	16b. KIND OF BUS	HNESS/INDUS	TRY	
Elementary/Secondary (0-12) 7th Grade	College (1-4 or 5+)							
17. FATHER'S NAME (First, Middle, Last)			emaker	16 MOTHED'S NAI	ME (First, Middle, Maiden	n Hom	<u>e</u>	
Benjamin Lindem	аии			The state of the s	eth Hudson			
19a. INFORMANT'S NAME (Type/Print)	witt -	19b. MAILING A	DDRESS (Street a		oute Number, City or Town		refe1	
Raymond Rudacil	Po			Avenue				
20a. METHOD OF DISPOSITION		PLACE AND DATE OF	_		DATE 20c. LO			
1)(Buriel 2 Cremation 3 Remo	oval from State cem	etery, crematory or other	(Place) oton	u 3/30	193 Ra	ltimo.	re, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LIC	DOKE () //	Julius Julius II	22 NAME AN	D ADDRESS OF FAC	HLITY 2	1.0	1 01 =	
· (had m	- For		7922	Kuck tun Wise Ave	eral Home nue Dunda	ob Vu Uk, M	ndalk, Inc. aryland 21222	
23. PART I. Enter the diseases, or c	omplications that caused list only one cause on a	the death. Do no	t enter tha mo	de of dying, such	as cardiac or respl	ratory arres		
IMMEDIATE CAUSE (Final	List only one cause on a	ich iina.					Interval Between Onset and Death	
disease or condition resulting in death)	. Conges	tive Hear	t Failu	re				
Testing III deatily		CONSEQUENCE OF):						
Comment to the control of the	o							
Sequentially list conditions, if any, leeding to immediate	DUE TO (OR AS A	CONSEQUENCE OF):						
CAUSE (Disease or Injury								
that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
d								
PART II. Other significant conditions	contributing to death be	ut not resulting In	the underlying	cause given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS	
22					PERFOR		AMULABLE PRIOR TO COMPLETION OF CAUSE	
					1 _ YES 2	X NO	DF DEATH?	
							1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL			26. PL	ACE OF DEATH (Che	ck only one)		1	
EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:					
27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	OF 28c, INJI	9 5 Residence	28d. DESCRIBE HOW II	JURY OCCU	RED	
1 🔀 Xetural 5 🗌 Pending	(Month, Day, Year)	INJUI	WO WO	RK? 'ES 2 NO			-	
2 Accident Investigation 3 Suicide & Could not be	28a. PLACE OF INJURY	- At home, ferm, str			28f. LOCATION (Street a	nd Number or	Rural Route Number	
4 Homicide detarmined	building, etc. (Spec	ify)	- 1011 - 102		City or Town, State)			
29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of my knowl	edge, death occurred	at the time, data	and place, and due	to the cause(a) and man	ner se stated		

COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)
19810 1012 OLD N. POINT Rd. Balt Md. 21224.

29d. DATE SIGNED (Month, Day,

3/27/93



020	funding physician.	etely filled in by the funeral director, page 5 should be detained for use as the burial-brane
7 tr 2 5-0020	3	F use as the
BALTIMORE, MARYLAND	the hospital	detached to
ARYL	ned by	ould be
E, M/	be reta	age 5 sh
MOR	аде 6 та	director, p
ALTI	death. P	funeral
B	thin 24 hours after death. Page 6 may be retained by the hospital	lled in by the
, ,	thin 54	etely fi

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the house of the house of the physician.	
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detained for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hydiene prior to burial, cremation, or removal.	, 3 should
IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitied at once.	

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last) RICKY	David	S	NEED	2. DATE OF DEATH DAY 7 YEARS 11:47 A				
-	4. SOCIAL SECURITY NUMBER 220-66-0792	5. SEX 6. AGE (In		UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) 8-17-1955	Count			
œ	9a. FACILITY NAME (If not institution, give st	reet and number)	91	D. CITY, TOWN OR LOCATION OF E	EATH	9c. COUNTY OF			
DIRECTOR	NORTH ARUNDEL H			GLEN BURNIE		<u>A.</u>	A. COUNTY		
DIRE	Maryland 106. COUNTY	Baltimore	10c. CITY, T	own or location Dund	lalk		10d. INSIDE CITY LIMITS? 1 YES 2XX NO		
FUNERAL	100. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?		
UNE	1822 Marshall Ro	12. WAS DECEDENT EVER IN U FORCES? 1 YES		27 22 13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Yes		ited States E — American Indian, ik, White, etc.		
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DAT		If yes, specify Cuban, Mexic 1 YES 2 NO Speci		Spec			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Give kind of work life. Do NOT use re	done during most of working	16b. KIND OF BUS	SINESS/INDUSTRY	with		
APLE	Elementary/Secondary (0-12)	College (1-4 or 5+) 2 Years		Service	Mana	aement			
	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA	AME (First, Middle, Maiden	Surname)			
BE	William David SV 1911. INFORMANT'S NAME (Type/Print)	<u>eed</u>	19b. MAILING AO	Barbar ORESS (Street and Number or Rural	a Anne Sto	Ripher.			
٩	Mr. & Mrs. Willi	am D. Sneed		North Boundary	Road Dune	dalk, Ma			
	20a. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	rval from State comet	LACE AND DATE OF D ary, crematory or other	pincel		CATION — City or To			
	21. SIGNATURE OF HOMERAL SERVICE LIC	ENSEE	nounce r	22. NAME AND ADDRESS OF FA	KCILITY		-		
4	de segon	Ces		Duda-Ruck Fu 7922 Wise Ave	muo Dunda	Oh Waren	alk, Inc.		
	21. PART I. Enter the disease, or canock, or theart failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in desth)	ist only one ceuse on aac	h iina.	1 / 1 / .		ratory errest,	Approximate interval Between Onset end Death		
CERTIFICATION	Sequentisity list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST								
BY PHYSICIAN: MEDICAL	PART II. Other significant conditions	contributing to deeth but	not resulting in t	ne underlying ceuse given in	Part I. 24a. WAS AN PERFOR 1 YES 2	MED?	D. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 \(\subseteq \text{NO} \)	HOSPITAL:		28. PLACE OF OEATH (C/					
H H	27. MANNER OF OEATH	1 Inpatient 2 ER/Outpati 28a. OATE OF INJURY (Month, Day, Year)	28b. TIME OF	Nursing Home 5 KResidence 28c. INJURY AT WORK?	8 Other (Specify) 26d. DESCRIBE HOW IP	JURY OCCUREO			
	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	280. PLACE OF INJURY —		M 1 YES 2 NO	004 1 004710N (O				
COMPLETED	4 Homicide 8 Could not be determined	building, atc. (Specify,)	t, rectory, drifted	281. LOCATION (Street a City or Town, State)	no number or Hurai i	Houte Number,		
MPLE	29a. CERTIFIER (Check only one)	IAN: To the best of my knowled	ge, death occurred a	the time, date and place, and due	to the cause(e) and man	ner as atated.			
	29b. SIGNATURE AND TITLE OF CERTIFIER	: On the basis of examination a	nd/or investigation, in	my opinion, death occured at the					
O BE	William 9 L	attack 4	公	D143	92	P 3/2	RIG 3		
-	30. NAME AND ADDRESS OF PERSON WHO WILLIAM BATTAI	LE. M.D. /4813	FORT SUN	NER DRIVE/BET	HESDA, MD.	20816	/		
	31. OATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNATI	URE						
	MAR 3 1 1993	Julia Devidson-A	andelle						

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DIVISION VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OF ATTICLA PROCEDATION THE LABOR TO A CONTROL OF THE HOSPITAL OF ATTICLA PROCEDATION TO THE HOSPITAL OF ATTICLA PROCEDATION AND THE RUNERAL DIFFERING AND THE RUNERAL DIFFERING AND THE RUNERAL DIFFERING AND THE RUNERAL DIFFERING AND THE RUNERAL DIFFERING AND THE RUNERAL DIFFERING AND THE STATE DEPT. OF Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is married, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE	0F	MARYLAND	DEPARTMENT	OF	HEALTH	AND	MENTAL	HYGIENE
		C	ERTIFICATE	O	F DEAT	H		REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC	MENT OF H	EALTH AND I DEATH	MENTAL HYGIEN		
Š	1. DECEDENT'S NAME (First, Middle, Las	7. SMIT	4			2. DATE OF DEATH	AY 93 YEA	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 218-29-2112	5. SEX 8. AGE		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		IRTHPLACE (State or Foreign punity)
OR	Sa. FACILITY NAME (If not institution, give	RE RUX	TON .		SON DE	АТН	9c. COUNTY C	F DEATH TIMORE
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	TY	10c. CITY I	TOWN OR LOCATI				10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	PRIMORE	CO. P/	101.	ZIP COOE		10g. CITIZEN	1 TYES 2 THO OF WHAT COUNTRY?
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER I	YY7, C	13. WAS DECE	2123	IIC ORIGIN? (Specify Ve	8 or No.— 14, F	IS A.
Β¥	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 TYES		If yes, spe		n, Puerto Rican, etc.)	6	Herek, White, etc.
COMPLETED	15. DECEDENT'S ED (Specify only highest gra-	DUCATION de completed) College (1-4 or 5 +)	16a. DECEOENT'S US (Give kind of work life. Do NOT use n	k done during mos	N t of working	16b. KIND OF BU	ISINESS/INDUSTR	N
OMPL	17. FATHER'S NAME (First, Middle, Last)	-	Home	MAK	EK			
BE CO	CHARLES +	HENRY K	EESE		MINI	ME (First, Middle, Maider	MME	NSTAFFER
10	19a. INFORMANT'S NAME (Type/Print)	LECORDS	19b. MAILING AC	OORESS (Street an	AS	Poute Number, City or For	Vn State, Zip Code)
	20a. METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State 20t	PLACE AND DATE OF CONTROL OF CONTROL	place ARK	CEM!	3-30 B	OCATION — City of	RE CITY
	21. SIGNATURE OF FUNEBAL SERVICE I	ICENSO G	11C,#	22. NAME AN	ADDRESS OF FA	UNERAL	St	APOL WILL
	23. PAPI I. Enter the discores, or	complications that ceuse	the daeth. Do not	enter tha mod	le of dying, sucl	as cerdiac or resp	olretory arrest,	Approximate
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. METASTADIC COON CARCINOMA Outside the country of the coun							
NO	Sequentially list conditions, DUE TO (OR AS A CONSCOURAGE OF):							
-ICAT	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	c	CONSEQUENCE OF):					
CERTIFICATION	that initiated events resulting in death) LAST	d	CONSECUENCE OF):					
AL A	PART II. Other significant condition	ons contributing to death b	ut not resulting in t	the underlying	cause given in	Part I. 24a. WAS AF	DIAFOG	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC						1 YES :	2 NO	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
	25. WAS CASE REFERRED TO MEDICAL			20 01 /	ICE OF DEATH (Che			
PHYSICIAN:	EXAMINER?	HOSPITAL:		THER:		6 Other (Specify)		
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	Y WOR	RY AT IK? ES 2 NO	28d. DESCRIBE HOW	INJURY OCCURE	
0	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined	28a PLACE OF IN ILIPY	— At home, ferm, stre-	et, factory, office		281. LOCATION (Street City or Town, State	and Number or Ru	ral Route Number,
COMPLET		SICIAN: To the best of my know						
w l	29b. SIGNATURE AND TITLE OF CERTIFI	ER: On the besia of examination	and/or investigation, I	n my opinion, de	29c. LICENSE NUM			se(s) and manner as stated.
TO B	30. NAME AND ADORESS OF PERSON W	THO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pri	int)	U348	27	b 3/2	19/93
	JAMES 31. DATE FILEO (Morith, Day, Year)	EBELI!	VG A	ND	7401	ISLER D	K S'UI	TE202 D 721204
	MAR 3 1 1993	Alia Davidson-1	fondall			Tows	on M	D 721204

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

MAR 3 1 1993

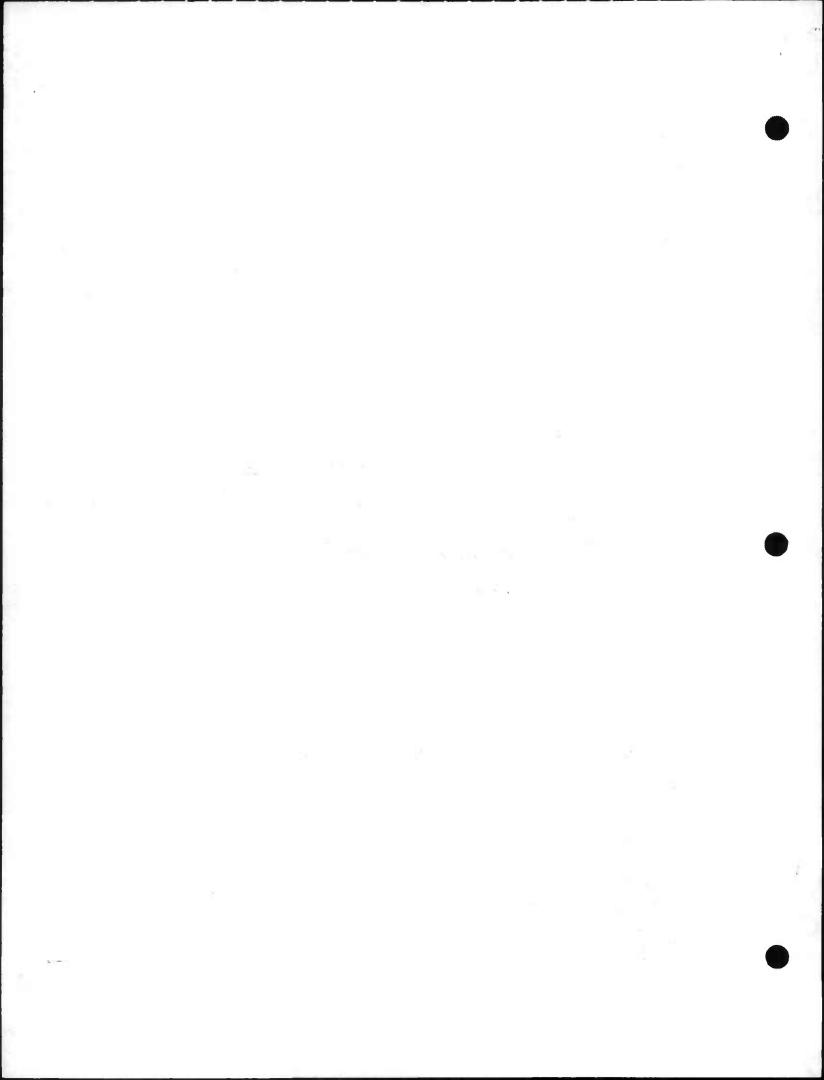
TO THE FUNCTOR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNCTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

								9:	3 (8652
	1 - STATE REGISTRAR	STATE OF MARYLAND			T OF HEALTH A		TAL HYGIEN REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) SCHMIDT 2. DAI						ATE OF DEATH	W 93 Y	EAR 3.	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 217-09-4202	5. SEX 8. AGE (In yrs.	lest birthday) VRS.	IF UNDI	DAYS HOURS	MIN. (M	TE OF BIRTH onth, Day, Year)		Country)	CE (State or Foreign
NC NC	9a. FACILITY NAME (If not institution, give:	street and number)		96. CIT	Y, TOWN OR LOCATION	OF DEATH		9c. COUNTY	OF DEAT	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	γ	10c. CIT	Y. TOWN	OR LOCATION					I. INSIDE CITY
	MD. BA	LTO. CO.	E	25	EX					LIMITS? VES 2 P NO
FUNERAL	100. STREET AND NUMBER	IN AVE			101. ZIP CODE	221		10g. CITIZEI	S &	COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ARMED NO	13	WAS DECENOENT OF If yes, specify Cuben. 1 VES 2 NO	Maxican, Puer	GIN? (Specify Yes to Rican, etc.)	or No — 14	Specify:	American Indian, hita, eto
	15. DECEDENT'S EDU (Specify only highest grade	ICATION 16a.	DECEDENT'S	USUAL	OCCUPATION during most of working		16b. KIND OF BUS	I BINESS/INDUS	WH.	178
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	SCRE	retired.	1 OFFICE	MGR		RY L NKIN		WERA Ltom
ш	17. FATHER'S NAME (First, Middle, Last) LOUIS MOL	2			18. MOTHE	R'S NAME (FIR	st, Middle, Maiden		15	
TO B	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE									
	20a. METROD OF DISPOSITION 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Color (S									
	21. SIGNATURE OF FUNERAL SERVICE LI	J- gan m	C. #	22	NAME AND ADORESS	OF FACILITY FUNK	RAL C	21494	PA	Krine.
	23. PART I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory srrest, index, or hear failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition									
	disesse or condition resulting in death)	e. QUE TO (OR AS A CONSEQUENCE OF):								
NO	Sequentially list conditions,	· CAD.								
CATI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury	DUE TO (OR AS A CON	SEQUENCE OF	F):						
ERTIFICATION	that initiated events resulting in deeth) LAST	DUE TO (OR AS A CONS	SEQUENCE OF	F):						
0	PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
PHYSICIAN: MEDICAL							PERFOR		CO	ILABLE PRIOR TO IPLETION OF CAUSE DEATH?
: ME		1 YES 2 N							YES 2 NO	
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			26. PLACE OF DEA	TH (Check only	one)			
IXSI	1 TYES 2 NO	1 - Inpatient 2 - ER/Outpatient	_		rsing Home 5 Resid	dence 6 🗆 O	ther (Specify)			
ВУ РН	27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 YES 2									
	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — At building, etc. (Specify)	home, farm, s	street, fac	tory, offica	26f. L	OCATION (Street a ity or Town, State)	nd Number or	Rural Route	Number,
COMPLETED		ICIAN: To the best of my knowledge, ER: On the basis of examination end/							Buse(B) en	menner ee stated
BE CC	296. SIGNATURE AND TITLE OF CENTER	M			29c. LICENS	SE NUMBER		29d. DATE S		
TO B	30, NAME AND ADDRESS OF PERSON WH	O COMPLETED CALLES OF SEATH OF	TEM OF CT	B	0	-22:	5/4	1 3	126	143

DHMH-16 Rev 1/89

SUITE

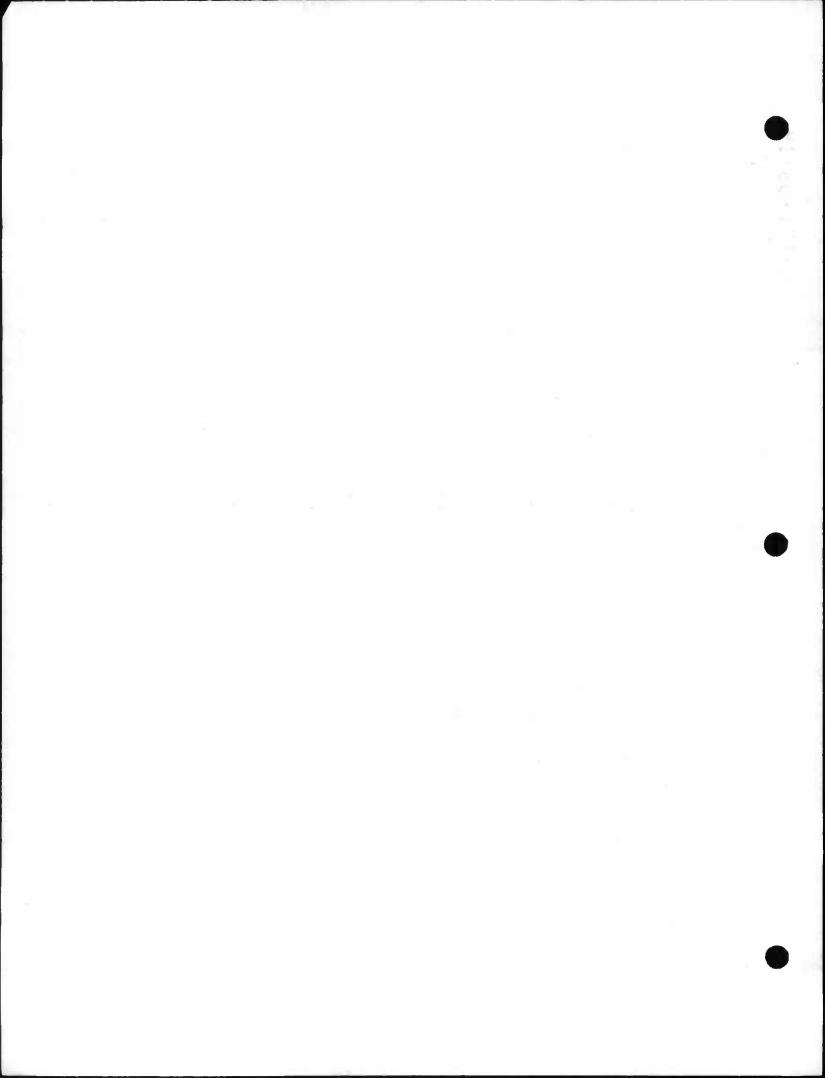


DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR	
1. DECEDENT'S NAME (First, Middle,	Last)
JOANNE	SH

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEATH
	JOANNE							MARCH	DA	. 199	YEAR	9:55 P M		
	4. SOCIAL SECURITY NUMBER		JMAKER 5. Sex	6. AGE (In yrs. less	birthday)	IF UNDER	1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF	BIRTH	, 13	8. BIRTHPLACE (State or Foreign	
	216-56-68	41	1 □ M 2 🔀 F	45	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, De	y. Year) -47		Counti	ryland
	9e. FACILITY NAME (If not institution, give street end number)					9b. CITY	TOWN C	OR LOCAT	ON OF DE			9c. COU	NTY OF D	4
8	THE JOHNS HOPKINS HOSPITAL			ΓΑΙ		BALTIMORE CITY					BALTIMORE			
ַ	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY				40.00	10c, CITY, TOWN OR LOCATION					1 DALTIMORE			
DIRECTOR	Maryland				10c, CIT	r, IOWN C	DH LOCAT	ION	Ba 1	timo	re.			10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER						404	ZIP COD						1 X YES 2 NO
FUNERAL	1532	Easter	n Aven	ue			101	. ZIP COU	ic.			10g. Ci i	USA	VHAT COUNTRY?
3	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.S. ARI	MED	13.	WAS DEC	ENDENT	OF HISPAN	IC ORIGIN? (S	nacify Yes	or No	14 BACE	- American Indian
	1 Never Married 2		FORCES? 1 IF YES, GIVE W	YES 2 N	0		t yes, sp	ecity Cubi	in, Mexicer Specify	, Puerto Rica	n, etc.)		Speci	— American Indian, c, White, etc.
) BY	3 Widowed 4 No Divo												орос	white
E	(Specify only	EDENT'S EDUCA y highest grade co	TION Impleted)	16a. DE6 (G/	DEDENT'S WE kind of W	USUAL Of	CCUPATIO	ON st of worki	ng	16b. KIN	ID OF BUS	INESS/INE	USTRY	
COMPLETED	Elementary/Secondary (0	. 1	College (1-4 or 5 -	,	Home									
OM	17. FATHER'S NAME (First, M				TOME	man	er	10 HOT	UEDIO MAS	RE (First, Midd				
	The second	s McCa	111 AV							Shea		Sumeme)		
BE	19e. INFORMANT'S NAME (7		илсу	19b	MAILING	AOORESS	(Street a			oute Number, (_	State Zir	Code	
5	Mary De	nbow		200					Roa					ID 21211
185	20a. METHOD OF DISPOSIT 1 ☐ Burlel 2 🂢 Cremetic		al tram Ctata	20b. PLACE A	NDDATEO	FDISPOS	ITION (Na	me of		OATE	20c. LO	CATION		
i i	4 Donation 5 Other	(Specify)		ME T	R'O' O' C	rem	ato	ry		3/31	Cat	onsv	/i11	e, MD
8	21. SIGNATURE OF FUNERA	L SERVICE LICEN	YSEE /	1					SS OF FAC	ылу s Fur	20.50	1 II.	. m.o	
9	Jepus	n Hen	2 Cin	penty	2					Road				MD 21211
3	23. PART I. Enter the d	hadses, or cor	mplicationa the	t caused the decise on each line.	th. Do n	ot antar	tha mo	da of dy	ing, such	ss cardiac	or respin	ratory sm	est,	Approximats
~	IMMEDIATE CAUSE (FIR		st only ona cau	A /			^	. /						Interval Between Onset and Death
	disease or condition resulting in dasth)	→	/	Acute	111	ler	tai	lur	0					1 days
	1		OUE TO	(OR AS A CONSEO	UENCE OF) :			-					2
NO N	Sequentially list conditi		DUE TO	CIVYNO	512									2 years
AT	if sny, leading to immed csuse. Enter UNDERLY!	NG T	502 10	Alcoho	OENCE OF	1150								20 Henre
띮	CAUSE (Disesse or Inju that initiated events	ry a.	DUE TO	(OR AS A CONSEO	UENCE OF);								ac years
CERTIFICATION	resulting in dasth) LAS	T d.												
	PART II. Other significa	nt conditions	contributing to	death but not a	authla a le		al and a discourse							
MEDICAL	Benal	Failu	VP)	death but not re	auiting ii	n tha un	deriying	cause	given in F	Part I. 244	PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
		intestic	101 6	leed						1[YES 2	□ NO		OF OEATH?
		111163711	10(1 0)	leed_						-				1 TES 2 NO
¥.	25. WAS CASE REFERRED TO	O MEDICAL					26. Pt.	ACE OF D	EATH (Cher	ck only one)				
PHYSICIAN:	1 YES 2 NO	1 1	OSPITAL:	ER/Outpatient 3	□ DOA	OTHER	t:			Other (Sp	ecify)			
Ě	27. MANNER OF DEATH		28e. OATE OF (Month, De	INJURY	28b. TIME	OF	28c. INJU	JRY AT		28d. DESCRI		JURY OCC	CURED	
βÁ		Pending Investigation	I I I I I I I I I I I I I I I I I I I	ay, rour,	INJU	M	1 Y	ES 2	NO					
	3 Suicide 6	Could not be	28e. PLACE Of building,	F INJURY — At honetc. (Specify)	ne, term, st	treet, tecto	ory, office)		261. LOCATIO	N (Street e	nd Number	or Rural R	oute Number,
COMPLETED	4 Homicide	determined									www. Grain)			
7	29 . CERTIFIER (Check only	IFYING PHYSICIA	N: To the best of	my knowledge, dea	th occurre	d at the ti	me, date	end piece	, end due t	to the ceuse(e) end men	ner ee stat	ed.	
Š	one) 2 MEDI	CAL EXAMINER:	On the besie of ex	remination end/or in	rvestigation	n, In my o	pinion, de	eath occur	red at the t	lme, date and	place, end	due to th	e ceuse(e	end menner ee stated.
w	296. SIGNATURE AND TITLE	OF CERTIFIER	40	L. 1. 1	0			29c. LICI	NSE NUMI	BER		29d. DATI	SIGNED	(Month, Ohy, Year)
10 B	- Klamal VI4	uuc, M	IN,	yesident	pau	pice	an					•	3/1	16/93
	30, HAME AND ADORESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITEM	27) (Type,	Print)	h.1	11	Ral	1/1	1	11 Λ	1	1150
	31. DATE FILED (Month, Day,	1111/181	John	1) Link	10)	1403	PITO	u,	DUI	timore	1 /1	ND	d	1281
	Anna		0. Pon	R'S SIGNATURE										
	MUK 01 1	993 4	de la land	san Mardal	1									



8. BIRTHPLACE (State or Foreign

Maryland

9c. COUNTY OF DEATH

10g, CITIZEN OF WHAT COUNTRY?

Specify:

USA

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 - YES 2 1 NO

white

21227

Interval Between

Onset and Death

Approximate

24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE

1 _ YES 2 _ NO

OF DEATH?

29d. DATE SIGNED (Month, Day, Year)

1120A M

REG. NO. 2. DATE OF DEATH

FOR

1 -

STATE REGISTRAR

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WILLIAM

31. DATE FILED (Month, Day, Year)
MAR 3 1 1993

3 1 1993

MONT Wa a 30 4 SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 1 🕁 M 2 🗌 F YRS. 215-03-7034 01 - 18 - 12use as the burial-transit permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR St. Elizabeth's Home Baltimore City RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Maryland Baltimore Catonsville 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 2306 Rockwell Avenue 21228 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 - YES 2 1 NO Specify BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Por y/Secondary (0-12) College (1-4 or 5+) 12th Steel Mfg. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Supervisor 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Rhinehart Schweinsberg Ħ Sophie Houck notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Madeline Schweinsberg 2306 Rockwell Avenue, Catonsville, Maryland 21228 90 20s. METHOD OF DISPOSITION
1 X Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Cathedral Cemetery 4/2/93 New Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Md. medicai 23, PART I Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel DUE TO OU AS the disease or condition resulting in death) 0 within event, AS A CONSEQUENCE OF): other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING law requires that the death certificate CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 YES 2 NO shows a PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 NO DR ATTENDING PHYSICIAN: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, INJURY 1 Netural 5 Pending 1 YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — At home, larm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homicide IMPORTANT: If Item 29a. CERTIFIER (Chack ank 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER P30182 BE 표보를 Musellos

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

RUSSERL

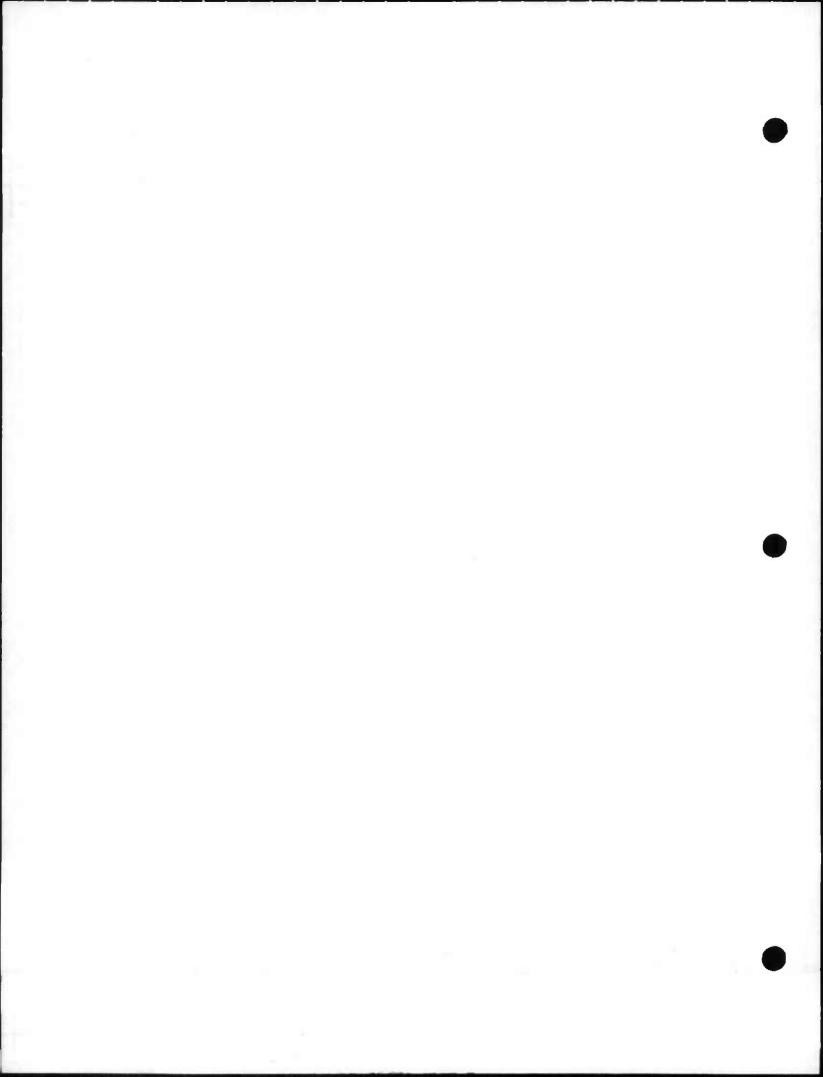
32. REGISTRAR'S SIGNATURE

3320

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

DHMH-18 Rev 1/89



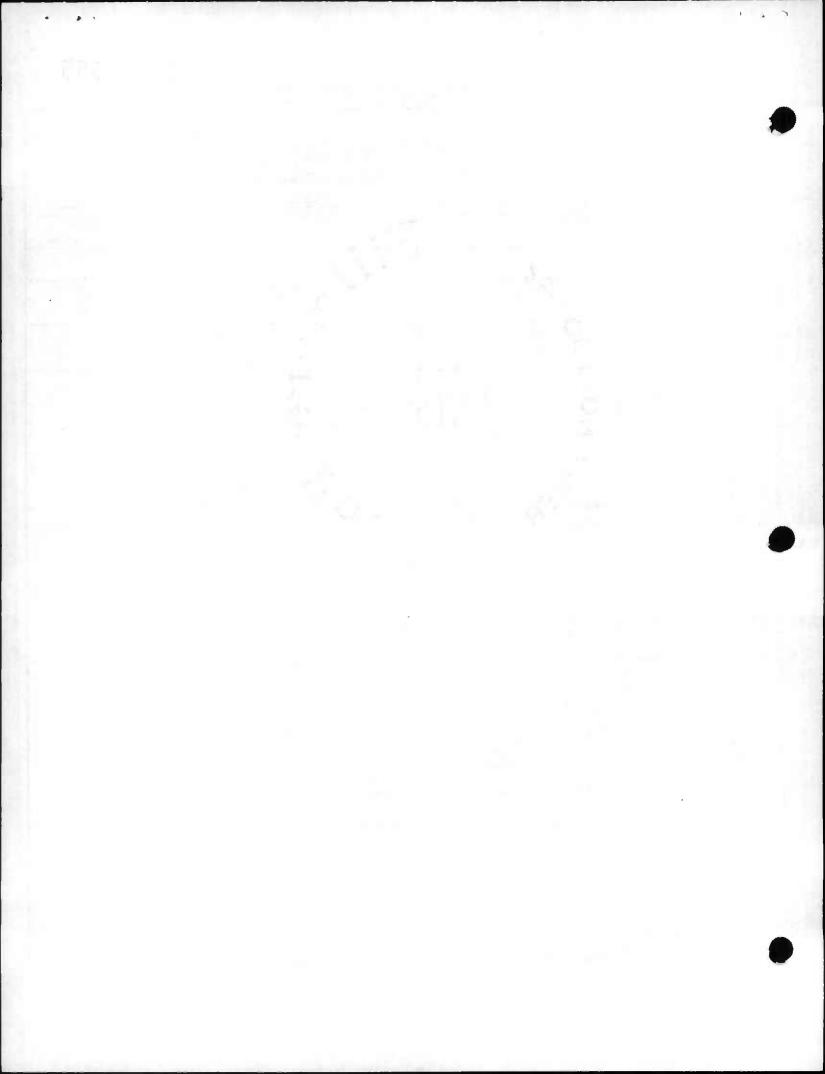
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

|--|

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLANDZ1315-0020

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H			GIENE S. NO.	00000
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEA	ATH	3. TIME OF DEATH
		uhmer He	enry Stub	nmer		03	29 9°	3 2:04 8 M
	410	1 M 2 D F 82	in yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Mgrith, Dwy.)	19/0 1	BIRTHPLACE (State or Foreign Country) Maryland
œ	9a. FACILITY NAME (If not institution, give st	reet and number)			R LOCATION OF DE		9c. COUNT	Y OF DEATH
DIRECTOR	Mercy Hospital				Baltimor	е		
3EC	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCAT	ION			10d. INSIDE CITY
	Maryland		F	Baltimor	е			LIMITS?
AL	10e. STREET AND NUMBER	0	11.	101.	ZIP CODE			N OF WHAT COUNTRY?
FUNERAL	411 N. Ellwa	Lave, B	actin	de	UD -	-2/12	1 1	U. S. A.
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 X YES	U.S. ARMED		ENDENT OF HISPAN		Ify Yes or No- 14	I. RACE — American Indian, Black, White, etc.
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA			2 NO Specify		()	Specify:
	15. DECEDENT'S EDUC	CATION	16a. DECEDENT'S I	ISHAL OCCUPATIO	M.	105 KIND	OF BUSINESS/INDUS	While
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of w life. Do NOT use	ork done during mos	st of working	10B. KINU (DF BUSINESS/INDUS	SIRY
7	na	na	Engi	neer		1	Food Chai	in
OM	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA			
BE C	Henry J. Stuhmer					eidbaue		
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street ar	nd Number or Rural F	Route Number, City	or Town, State, Zip Co	ocie)
2	Marian E. Stuhmen	(Wife)	411 N	I. Elwood	d Ave.,	Baltimo	re, Md. 2	21224
	20a, METHOD OF DISPOSITION 1 X Buriet 2 Cremetion 3 Remo	20b.	PLACE AND DATE O	F DISPOSITION (Ner	me of	DATE 2	DC. LOCATION — CIT	ly or Town, State
	4 Donation 5 Other (Specify)	(Bardens C	f Faith	Cemeter	y 4/1	Baltimo	re, Md.
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			unek Fun		mo	
	hum	1) This	V					Md. 21213
	23. FART I. Enter the diseases, or c	omplications that caused list only one cause on as	tha daath. Do no	ot enter tha mod	de of dylng, such	h aa cerdiac or	respiratory arres	t, Approximate
	IMMEDIATE CAUSE (Final	List only one cause on as	ich iina.					Interval Between Onset and Death
		. Sen	515					
	resulting in death)	DUE TO (OR AS A	SIS):				
NO	resulting in death)	DUE TO (OR AS A Unin	SIS CONSEQUENCE OF My to	et inj	Lechru.			
ATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A DUE TO (DR AS A	SIS CONSEQUENCE OF	et inf	Lechru.			
FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (DR AS A	consequence of	net inf	Lechru.			
RTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING	DUE TO (DR AS A	CONSEQUENCE OF	net inf	Lechru.			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	ret inf				
AL	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A DUE TO (OR AS A	consequence of	the underlying			AS AN AUTOPSY ERFORMED?	24b. WERE AUTOPSY FINDINGS
AL	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A DUE TO (OR AS A	consequence of	the underlying		PI		
AL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A DUE TO (OR AS A	consequence of	the underlying		PI	ERFORMED?	24b. WERE AUTOPSY FINDINGS AMILLABLE PRIOR TO COMPLETION OF CAUSE
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AL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions Church Ohs Michael Charles 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A	CONSEQUENCE OF	the underlying	ceuse given in	1 Y	ERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions Chause Chis have the condition of the conditions of	DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A	CONSEQUENCE OF	the underlying 26. PLI OTHER: 4 Nursing Home OF 28c. INJT. WOF	ACE DF DEATH (Che	PI 1 Y	ERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ANO
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BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions Charact Ohs had 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH 1 Netural 5 Pending	DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A EXECUTE: B. CONTRIBUTION DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A	CONSEQUENCE OF CONSEQUENCE OF ut not resulting in y D3-Constitute to the constitute of the constitu	28. PLI OTHER: 4 Nursing Home OF 28c. INJI RPY WOF	ACE OF DEATH (Che 5 G Residence JRY AT 147 ES 2 ND	8 Other (Specification DESCRIBE I	PERFORMED? YES 2 ANO Y) HOW INJURY OCCUR	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 MO
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BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions Charles Ohs Machine Charles of Charl	DUE TO (OR AS A DUE TO	CONSEQUENCE OF CONSEQUENCE OF Ut not resulting in the consequence of t	28. PLI OTHER: 4 Nursing Home OF 28c. NAJ. RY WOF M 1 Y reet, factory, office	ACE DF DEATH (Che 5 S Residence JRY AT RR? ES 2 ND	8 Other (Specific 28d, DESCRIBE In City or Your, to the cause(a) ar	PREPORMED? (ES 2 ANO (STREET and Number or State)	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 AO
COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions Charles Ohs Machine Charles of Charl	DUE TO (OR AS A DUE TO	CONSEQUENCE OF CONSEQUENCE OF Ut not resulting in the consequence of t	28. PLI OTHER: 4 Nursing Home OF 28c. NAJ. RY WOF M 1 Y reet, factory, office	ACE DF DEATH (Che 5 5 Residence JRY AT RK? ES 2 ND and place, and due	B Other (Specification of Specification of Specification of City or Town, to the cause(s) art time, data and pla	Y) HOW INJURY OCCUP Street and Number or State) Indicate the stated of the control of the contr	24b. WERE AUTOPSY FINDINGS AMILLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 MO RED Rural Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions Charl Chy had 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A L B contributing to deeth be AVE OF LIVERY (Morth, Dey, Year) 26a. PLACE OF INJURY building, etc. (Special Control of the best of my knowledge) CIAN: To the best of axamination	CONSEQUENCE OF CONSEQUENCE OF Ut not resulting in the consequence of t	28. PLI OTHER: 4 Nursing Home OF 28c. NAJ. RY WOF M 1 Y reet, factory, office	ACE DF DEATH (Che 5 S Residence JRY AT RR? ES 2 ND	B Other (Specification of Specification of Specification of City or Town, to the cause(s) art time, data and pla	Y) HOW INJURY OCCUP Street and Number or State) Indicate the stated. The stated of the control	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 MO RED Rural Route Number, cause(s) and manner as stated.
COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions Charlet Chymic Ch	DUE TO (OR AS A DUE TO	CONSEQUENCE OF CONSEQUENCE OF ut not resulting in	28. PLI OTHER: 4 Nursing Home OF 28c. INJL WOF M 1 Y reet, factory, office d at the time, date of the time, date of the time, date of the time.	ACE DF DEATH (Che 5 G Residence JRY AT ES 2 ND and place, and due esth occured at the 29c. LICENSE NUM	8 Other (Specification of Specification	Y) HOW INJURY OCCUP Street and Number or State) Indiamanner as stated. Indiamanner as sta	24b. WERE AUTOPSY FINDINGS AMILLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 MO RED Rural Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions Charlet Chymic Ch	DUE TO (OR AS A DUE TO	CONSEQUENCE OF CONSEQUENCE OF ut not resulting in	28. PLI OTHER: 4 Nursing Home OF 28c. INJL WOF M 1 Y reet, factory, office d at the time, date of the time, date of the time, date of the time.	ACE DF DEATH (Che 5 G Residence JRY AT ES 2 ND and place, and due esth occured at the 29c. LICENSE NUM	8 Other (Specification of Specification	Y) HOW INJURY OCCUP Street and Number or State) Indiamanner as stated. Indiamanner as sta	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 MO RED Rural Route Number, cause(s) and manner as stated.
BE COMPLETED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant conditions Charact Ohs have The first of the first of	DUE TO (OR AS A DUE TO	CONSEQUENCE OF CONSEQUENCE OF ut not resulting in	28. PLI OTHER: 4 Nursing Home OF 28c. INJL WOF M 1 Y reet, factory, office d at the time, date of the time, date of the time, date of the time.	ACE DF DEATH (Che 5 G Residence JRY AT ES 2 ND and place, and due esth occured at the 29c. LICENSE NUM	8 Other (Specification of Specification	Y) HOW INJURY OCCUP Street and Number or State) Indiamanner as stated. Indiamanner as sta	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 MO RED Rural Route Number, cause(s) and manner as stated.



3. TIME OF DEATH

REG. NO.

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

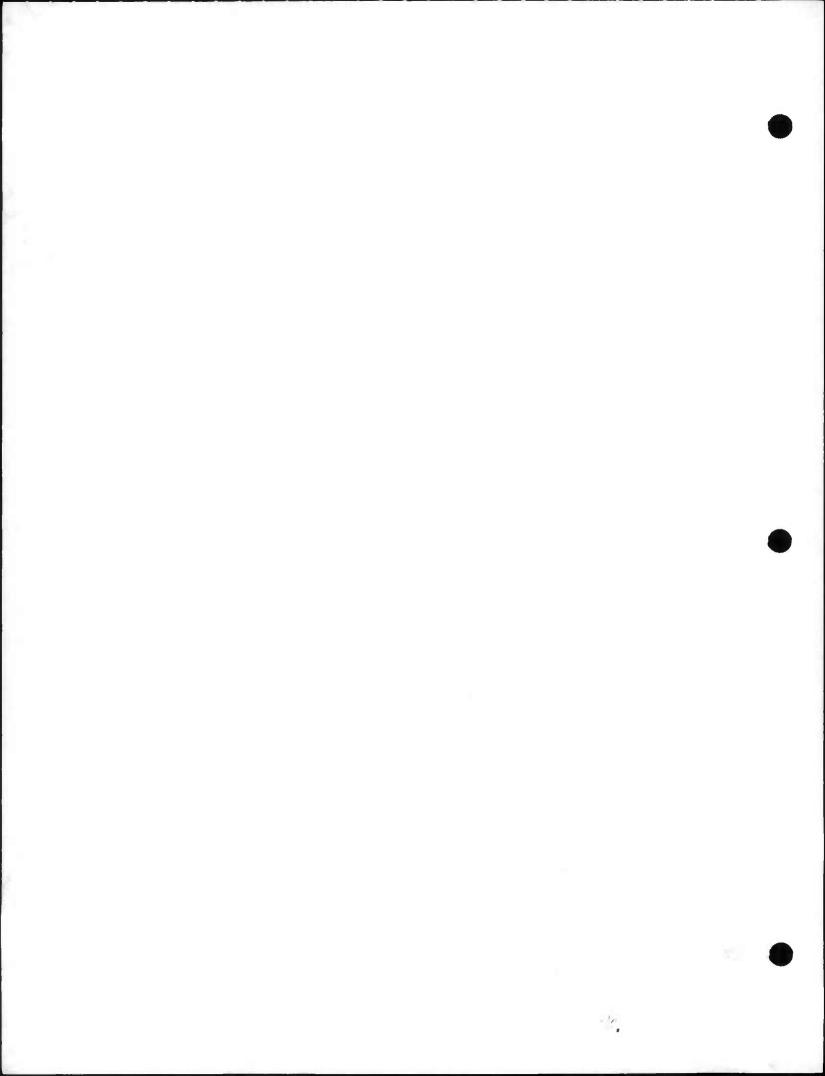
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	SPITAL

SHAMER 9 :30AM MARIE 03 93 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreig JF LINDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 5/7/04 213-74-9193 1 M 2 F YRS 88 Md. should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 Sykesville, Elder Care Sykesville Carroll RESIDENCE OF DECEDENT 10a. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Carroll Sykesville 1 YES 2 X NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7427 Smiths Private Road 21784 U.S.A. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yea, specify Cuban, Mexican, Puerlo Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Marrie IF YES, GIVE WAR OR DATES В 1 TES 2X NO Specify: 3 Wildowed 4 Divorced Specify White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade complete) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home notified at once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Henry Piquett Nellie M. Henderson BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 7427 Smith Private Rd. Sykesville, Md John J. Shamer pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 1 Donation 5 Other (Specify) director, Crestlawn Cemetery Md 3/30 Marriottsville, examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY funeral Haight Funeral P.O.Box 195 Sykesville, Md. Harry Home 21784 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cerdiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. à Approximate Interval Retween ŏ IMMEDIATE CAUSE (Finel Onset and Death and completely fille burial, cremation, the disease or condition_ reaulting in death) event, luonar. traumatic MEDICAL CERTIFICATION Sequentielly ilst conditione, DUE TO (OR AS A CONSEQUEN 2 ending physician a Hygiene prior to If any, leading to immediata cause. Enter UNDERLYING other 1 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 the atten Mental Injury. PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY WERE AUTOPSY FINDINGS 30 0 any PERFORMED? AVAILABLE PRIOR TO Signed Health a COMPLETION OF CAUSE Shows 1 TES 2 NO been L. of PHYSICIAN: Dept. the State D. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA ne 5 🗆 Residence & 🗆 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this (with Netural 2 Accident 5 Pending Investigation м 1 YES 2 NO B After 1 death 28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Sulcide 69 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. a Could not be DIRECTOR: hours after them 28 Is 4 Homicide COMPL CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL C DE filed within 72 h 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TILE OF CERTIFIER D 272 BE 93 2 30, NAME AND RODRESS WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 1993 mar . m. Ct. of to

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



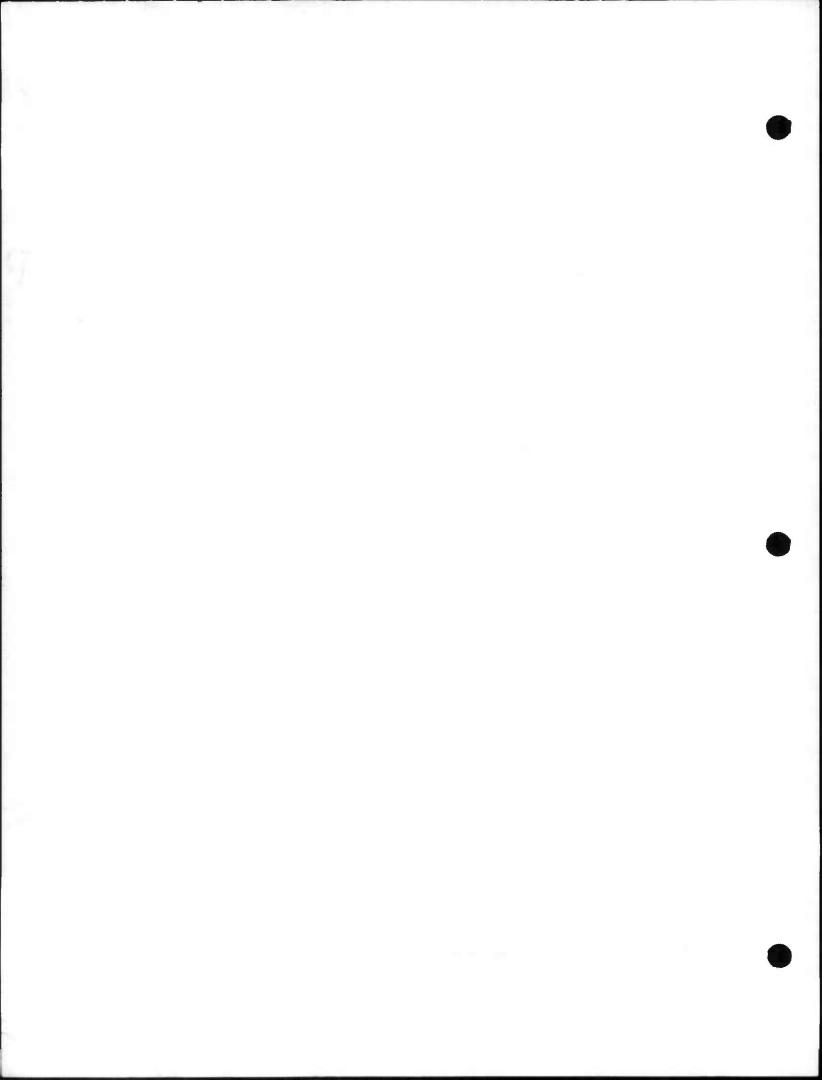
PITAL IN ATTENDING DAYSICIAN. The law remities that the flexib remities that he will be a second by the boosts of account of account of the second of the se	FRAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, same 5 should be detached fire use as the bundal paners have 1.2 should	hours after death with the	T. If Item 23 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR	TO THE FUNERAL DIR	be filed within 72 hou	IMPORTANT: If iter	

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

REG. NO.

	REGISTRAR		CER	TIFICA	TE OF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF				3. TIME OF DEATH
	TODD		THOMAS					- 2		93	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birth	nday) IF U	NDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH			PLACE (State or Foreign
	212-34-3606	XXM2□F	56 Y	RS. MONT	THS DAYS	HOURS MIN.	(Month, D	9-36		Country)
	9a. FACILITY NAME (If not institution, give s	treet and number)			CITY, TOWN	OR LOCATION OF DE			9c. COUNTY	V OF DE	MD
<u>۳</u>	1109 DARLEY A	VENUE		-	DALM	IMORE			1		
БI	RESIDENCE OF DECEDENT	THOE			DALI.	LMORE				_	
DIRECTOR	10a. STATE 10b. COUNTY	r	100	c. CITY, TO	WN OR LOCA	TION					10d. INSIDE CITY LIMITS?
	MD			BAL	TIMOE	RE				ľ	1 X YES 2 NO
A	10e. STREET AND NUMBER	-				. ZIP CODE			10g. CITIZEI	N OF WI	HAT COUNTRY?
E	1109 DARLEY A	VENUE				21218			II 9	S.A	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. ARMED			ENDENT OF HISPAN					— American Indian, White, etc.
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	YES 2 NO			ecify Cuban, Maxica 2/2/NO Specify		in, etc.)		Black, Specify	
	3 Widowed 4 Divorced					2171					LACK
百	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	(Give kir	nd of work d	L OCCUPATION	ON st of working	16b. KII	ND OF BUSIN	NESS/INDUS	TRY	
E I	Elementary/Secondary (0-12)	College (1-4 or 5 +	We On A	IOT use retir	ed.)						
₽ I	9th						C	ONST	RUCT	ION	
COMPLETED	17. FATNER'S NAME (First, Middle, Last)					18. MOTNER'S NA	ME (First, Midd	tle, Maiden Su	ırname)		
BE	CHARLES THOMAS	3				EVELY	N NIC	HOLSO	ON		
2	19a. INFORMANT'S NAME (Type/Print)		19b. MA	ILING ADDI	PESS (Street a	nd Number or Rural I	Route Number,	City or Town,	State, Zip Co	ode)	
-	MARY FRANCES (GREEN TH	HOMAS 110	09 D	ARLEY	AVE./I	ват.тт	MORE	, MD	21	218
	20a. METHOD OF DISPOSITION USPBURIAL 2 Cremetion 3 Remo		20b. PLACE AND D	ATE OF DIS	POSITION /Na		DATE		TION - City		
1	P☐ Donation 6 ☐ Other (Specify)		CEDAR			TETERY		AMMI	E ARI	מאד	EL CO, MD
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE)			D ADDRESS OF FA	CILITY		7,111	31312	DII CO7 100
	+ Bonnad S	2 anti	1.000],	WM C	MARCH	P H /	1101	E N	i O D	TH AVE.
	23. PART I. Enter the diseases, or o	non-Variana the	W JO T	-							
	shock, or heert fellure.	List only Dne ceu	se Dn eech iine.	DD not el	ner the mo	de or dying, suc	h aa cerdled	: Dr reepira	IDry arreel	t,	Approximete Interval Between
	iMMEDIATE CAUSE (Finel disease or condition		20			PC	0				Onset and Death
	resulting in death)	o. Ca	i ah	-01	na	108	23				Cincalls
		// 12	OR AS A CONSEQUEN	CE OF):	11.	1	1 3	111	-		f. To
CERTIFICATION	Sequentially list conditions,	» He	(OR AS A CONSEQUEN	CO1	nu	CRE (aci	cin	om	4	Omenus.
¥	If any, leading to immediate cause. Enter UNDERLYING	332.7	(OII AG A CONSCOULT	GE OF).							
윤	CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS A CONSEQUEN	CE OFI:							
E	resulting in death) LAST										į l
빙		1,									+
DICAL	PART II. Other aignificent condition	e contributing to	/	ing in the	underlying	g ceuse given in	Part I. 24	a. WAS AN AL			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
용비	Malhn	7n 1	Zen				1	YES 2 []			COMPLETION OF CAUSE OF DEATH?
									1		I □ YES 2 Ø(NO
z I											
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				28. PL	ACE OF DEATH (Che	ack only one)		_		
Sign	1 YES 2 NO	HOSPITAL:	ER/Outpatient 3 D		IER: Nursing Nom	a 5 N Basidenca	6 Other (Se	nec/fv)			
È	27. MANNER OF DEATN	26a. DATE OF	INJURY 28b	TIME OF	28c. INJ	URY AT	28d. DESCRI		URY OCCUR	ED	
7	Natural 5 Pending investigation	(Month, Da	ly, Year)	INJURY	1 1 1 N	RK? 'ES 2 NO					
BY	2 Deutstein	26s. PLACE OF	F INJURY — At home, fe	rm, street.			28f. LOCATIO	ON (Street and	1 Number or	Rural Ro	uta Number
品	4 Nomicide 6 Could not be determined	building,	etc. (Specify)		,,			own, State)	r trambor or .	riorar rio	oto Norrodi,
COMPLET	29a. CERTIFIER							_			
물			my knowledge, death or								
8	2 MEDICAL EXAMINE		amination and/or invest	igation, in i	ny opinion, d	eath occured at the	time, data and	I place, and o	due to the ci	ause(a)	and menner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	2 4		01	Λ	29c. LICENSE NUM	BER	r- 2	9d. DATE SI	GHED (Month, Day, Year)
2	a way	7 /	UD,	1h	D	1) 41.	27	>	5/	20	7/50
	30. NAME AND ADDRESS OF PERSON WNO	COMPLETED CAUS	E OF DEATH (ITEM 27)	(Type, Print)	HNS	400	KIN	10	6 01	10	CV 100
	31. DATE FILED (Month, Day, Year)	32 BEGISTRA	R'S SIGNATURE	10	1/14)	1101	ILIN	۲ ،	DIY	466	47 6116
8	MAR 3 1 1993 4	he Davidson	- gardete								



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DESCRIPTION OF THE DESCRIPTION OF THE PROPERTY	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.2.3 should	th the State Dept. of Health and Mertral Hyglene prior to burial, cremation, or removal.	marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
יום ומא וכקטוועם נוומו עום ססמו	has been signed by the atte	e Dept. of Health and Mental	m 23 shows any Injury,
I SI CENTRAL LINGUIST.	RECTOR: After this certificate	hours after death with the State	IMPORTANT: It item 28 is marked, or Iter
	TO THE FUNERAL DI	be filed within 72 hou	IMPORTANT: It Its

1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	ENT OF HE	ALTH AND MI DEATH	ENTAL HYGIEN REG. NO		
1. DECEDENT'S NAME (First, Middle, Last) Duane Wil	nde11	Talley		2	March 2.	3, 199 ³	3. TIME OF DEATH 6:28am
4. SOCIAL SECURITY NUMBER 212-60-6434 9a. FACILITY NAME (If not Institution, give steel) Maryland Genera	MBER 5. SEX 8. AGE (In yrs. lest birthdey) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Dey, Year) 40 YRS. MONTHS DAYS HOURS MIN. April 5 1952 9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH						
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, TO	OWN DR LOCATIO	N		<u></u>	10d. INSIDE CITY LIMITS?
Maryland 100. STREET AND NUMBER			Balti 101.2	MOTE CODE		10g. CITIZEN OF	1 TY YES 2 NO WHAT COUNTRY?
619 Hillview 11. MARITAL STATUS 1 M Never Married 2 Married 3 Widowed 4 Divorced	Road 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 X ND	If yes, spec	21225 IDENT OF HISPANIC Ify Cuben, Maxican, I	DRIGIN? (Specify Yes Puerto Rican, etc.)	or No — 14, RAG Ble	USA CE — American Indian, ck, Whita, etc. city:
15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) Callege (1-4 or 5+)	16a. DECEDENT'S USU (Give kind of work life. Do NOT use ret	done during most	of working	16b. KIND OF BU	[SINESS/INDUSTRY	Black
17. FATHER'S NAME (First, Middle, Last)	ollege 2	Assist			Richar		en, M.Y.C.
Henry H. Tall	ey				Grant	Surname)	
19a. INFORMANT'S NAME (Type/Print)				Number or Rural Rou	te Number, City or Tow		
Janice Forde	201	619 Hi				ore, M	
20g, METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Remo		netery, cremetory or other p Cedar Hil	place)		3/27 Ba:	All the second	2000
21. SIGNATURE OF FUNERAL SERVICE LIC	Pollino		22. NAME AND	ADDRESS OF FACIL	"Mutter Falls P	Funer	al Homes,
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Shook DUE TO (OR AS A ACQUIRED DUE TO (OR AS A OUE TO (OR AS A	a consequence of: a consequence of: a consequence of: Immuned De a consequence of:	eficienc	g with an	emia me	oldy arrost,	Approximate Interval Between Onset and Death
PART II. Other eignificant condition:	s contributing to death b	out not resulting in th	e underlying (euse given in Pa	rt i. 24e. WAS AN PERFOR	MED?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 22 NO	HOSPITAL:		HER:	E OF DEATH (Check			
27. MANNER OF DEATH 1** Neturel 5 Pending 2 Accident Investigation	1 ☆ Inpatient 2 ☐ ER/Outp 28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJUR	5 Rasidence 6 PAT 26 PAT 77 PA	Other (Specify) 3d. DESCRIBE HOW II	JURY OCCURED	
3 Suicide 6 Could not be 4 Homicide determined	26a. PLACE OF INJURY building, atc. (Spec	— At home, farm, street	, factory, offica	28	of. LOCATION (Street a City or Town, State)	nd Number or Rural	Route Number,
	CIAN: To the best of my know R: On the basis of examination						s) end manner as stated.
296. SIGNATURE AND TITLE OF CERTIFIER	res			9c. LICENSE NUMBE		29d. DATE SIGNED	3/23/93
30. NAME AND ADDRESS OF PERSON WHO Tatyana Pevz	mer, M.D.	c/o Mar	yland (General H	ospital		
MAR 3 1 1993 Ju	3.2 REGISTRAR'S WIGH	A. T.				·	

SERVICE OF THE STREET

FERING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	CTURE star this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Panes 1 2 3 should	esterment with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ACTEMBING PHYSICIAN	TO THE FUNERAL DIRECTUR. After this certifi	be filed within 72 hours after a with the	IMPORTANT: If Item 28 is marked, or

										9	13	08659
	FOR 1 - STATE REGISTRAR	STATE OF MARY		DEPARTMI RTIFICA				MENTAI	HYGIEN REG. NO.	E		
1	1. DECEDENT'S NAME (First, Middle, Last)			11111110				2. DATE	OF DEATH	av .	YEAR 3.	TIME OF OEATH
	ROBERT C. TERF	1	(in yrs. lest i	Control of the state of the sta	NDER 1 YEAR	T		03	30	2	93	6 AH
	078-12-9438	14 M 2 D F 6		YRS. MON	-	HOURS	MIN.	SEPT	OF BIRTH (, Day, Year) (, 22, 19	923	Country)	RETVILLE,
NO.	98. FACILITY NAME (II not institution, give s ST. ELIZABETH NUF	rtreet and number) RSING CENTER	(JENK	INS)	BALT I	MORE	ON OF DE				Y OF DEAT	ТН
DIRECTOR	10a. STATE 10b. COUNT	Y		10c. CITY, TO	MN OR LOCA	TION	-				1.10	Id. INSIDE CITY
	MARYLAND			B	ALTIM	ORE					100	LIMITS?
FUNERAL	100. STREET AND NUMBER 2050 HARMAN AVENU	UE			1	2123					S.A.	AT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 V YES IF YES, GIVE WAR OR WW	2 NO		If yes, s	CENDENT Copecity Cube	n, Mexica	n, Puerto F	? (Specify Yes lican, etc.)	or No-		American Indian, mite, etc. WHITE
TED	15. DECEDENT'S EDU- (Specify only highest grade	CATION a completed)	(Give	EDENT'S USUA	one during m		10	16b.	KIND OF BUS	HNESS/INDU	STRY	
COMPLET	Elementary/Secondary (0-12) H/S GRAD	College (1-4 or 5+)	Ilfe. D	TENANC	ed.)			MI	ECHANI	CAL E	NGINE CON	ERING SULTANTS
i w	17. FATHER'S NAME (First, Middle, Last) UNKNOWN		_			18. MOTH	HER'S NAI	ME (First, A	ficiale, Maiden	Surname)		
TO B	190. INFORMANT'S NAME (Type/Print) MARY F. HARMAN		19b. 2	MAILING ADD	RESS (Street RMAN	and Number AVENU	or Rural F	BALT	er, City or Town	MD .	21230)
	20a. METHOD OF DISPOSITION 1			OD DATE OF DIS etory or other pi CREMA		lame of		3/31		CATION — CI LTIMO	_	, State
	21. SIGNATURE OF FUNERAL SERVICE LIK	Susher				ARD FU	UNER	AL HO	OME, I JE-BAL		E, MI	21229
		complications that cause List only one cause on	ed the deat	th. Do not e								Approximate Interval Between Onset and Death
	immediate cause (Finel disease or condition resulting in death)	5000F	v C	ARDI	AC	DEA	74	•	_			Onset and Death
N	Sequentially list conditions,	a. JUDOF OUE TO (OR AS b. /Scitte	A CONSEQU	JENCE OF):	27	Disa	TAPE					3mm
CATIC	if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS ANOXIC	A CONSEQU	JENCE OF):								
ERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQU	IENCE OF):								
O	PART il. Other significent condition	ne contributing to death	but not res	sulting in the	underlyk	o cause o	niven in	Part I	24a, WAS AN	VPROTILIA	245 W	ERE AUTOPSY FINDINGS
MEDICAL									PERFOR	MED?	CC	AILABLE PRIOR TO OMPLETION OF CAUSE DEATH?
					_			_			1	YES 2 NO
IAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. F	LACE OF D	EATH (Che	eck only on	9)			
PHYSICIAN:	1 TES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Ou			HER: Nursing Ho	ne 5 □ Re	eldence	6 🗆 Other	(Specify)			
ву РН	27. MANNER OF OEATH 1 Netural 5 Pending Investigation	26a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY	W	JURY AT DRK? YES 2] NO	28d. OE\$	CRIBE HOW II	JURY OCCU	RED	
<u> </u>	2 Accident Investigation 3 Suicide 6 Could not be detarmined	28e, PLACE OF INJUR building, etc. (Sp	Y — At home	e, farm, street,	factory, offi	ce		281. LOCA	ATION (Street a or Town, State)	nd Number o	r Rural Rout	Number,
COMPLET		ICIAN: To the best of my kno										
BE CO	296. SIGNATURE AND TITLE OF CERTIFIER		//	MD) -t-unariti	29c. LICE	ENSE NUM				SIGNEO (M	onth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WH	9	FATH (ITEM	27) (Time Print)				. 0 2		> 3	-30	5-93

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

INILIAM RUSSAL M.O. 3320

INILIAM I 31. DATE FILED (MONTH, Day, Year) MAR 3 1 1993

BALT- MD 21227

AVE.

B ENSON

93

18. SOUTH

NONE

10g, CITIZEN OF WHAT COUNTRY?

Specify:

UNITED STATES

14. RACE — American Indian, Black, White, etc.

AFRICAN AMERICAN

9c. COUNTY OF DEATH

3. TIME OF DEATH

10d. INSIDE CITY

XIX YES 2 NO

4. BIRTHPLACE (State or Foreign

4:45 P M

CAROLINA

2. DATE OF DEATH

Ö 3

FOR STATE REGISTRAR

DECEDENT'S NAME (First, Middle, Last)

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HERBERT A. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BURTH 056-18-4911 DAYS HOURS 307 M 2 | F 04permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH OF MARIJAND DIRECTOR MAI VERSITY BALTIMORE CITY 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE CITY NONE FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 2407 W. LANVALE 21216 ST. detached for use as the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FDRCES? YES 2
IF YES, GIVE WAR OR DATES 2 ND 1 Never Married 2 Merried
3 Widowed 4 Divorced 1 YES 2 XNO Specify: BY WWII COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working (Give kind of work done life. Do NOT use retired.) entary/Secondary (0-12) College (1-4 or 5+) 9th grade MAINTENENCE SCHOOL SYSTEM none 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 2 notified at Toney L. Toatley Willie Alma James BE page 5 should 194. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Westley Toatley 2407 W. Lanvale Street 2 20a, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must FOREST VA CEM has been signed by the attending physician and completely filled in by the funeral director, Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 4 Donation 5 Other (Specify) GARRISON 21. SIGNATURE OF FUNERAL SERVICE LIG examiner 22. NAME AND ADDRESS OF FACILITY CALVIN B. SCRUGGS FUNERAL HOME PRESTON ST. 412 E. medical ses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23. PART I. Enter the disea shock, or heart failure. List only one cause on each line. (RESPIRATORY FAILURE) IMMEDIATE CAUSE (Final the disease or condition ESPIRATOR within 2 4 resulting in deathi event, DUE TO (DR AS A CONSEQUENCE DE) executed ARDS (ARDS) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEDUENCE OF): if any, leading to immediate PNEUMONIA) e cause. Enter UNDERLYING SPIRATION certificate other CAUSE (Disease or injury DUE TO (DR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST ò Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? shows any 1 | YES 2 10 PHYSICIAN: , Dept. MP R 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The Eem DIRECTOR: After this certificate hours after death with the State HOSPITAL 1 YES 2 OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 9 28a. DATE DF INJURY (Month, Day, Year) TIME OF 27. MANNER OF DEATH Natural marked, 26c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED 5 Pending Investige 1 YES 2 ND BY Accident OR ATTENDING 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 COMPLETED 8 Could not be 4 Homicide 28 determined tem CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. H4 MPORTANT: 11 2 MEDICAL EXAMINER: On the nination and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(a) and manner as stated. within 296. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 80-2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

quia ban has so me

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

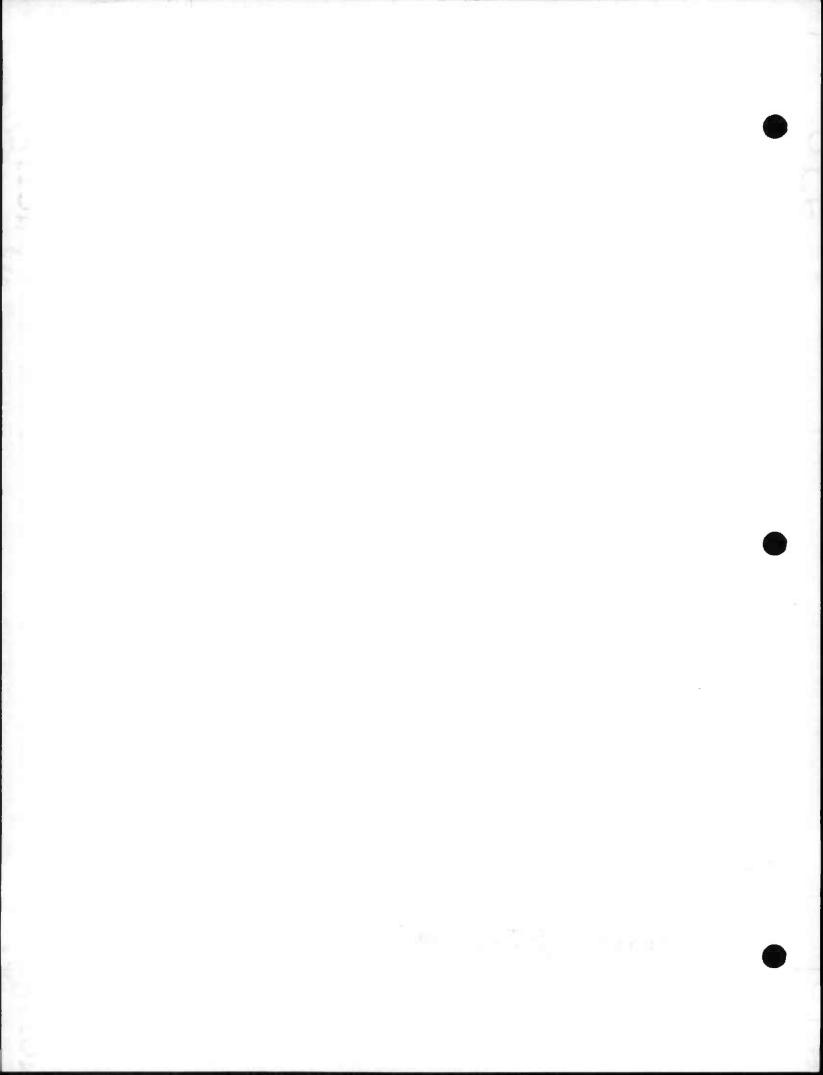
CERTIFICATE OF DEATH

TOATLEY

Balto, Md. 21216 20c. LOCATION — City or Town, State OWINGS MILLS. MD BALTO, MD 21213 Approximate interval Between **Onset and Death** 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 29d. DATE SIGNED (Month, Day, Year) 9 3 29 DHMH-16 Rev 1/89

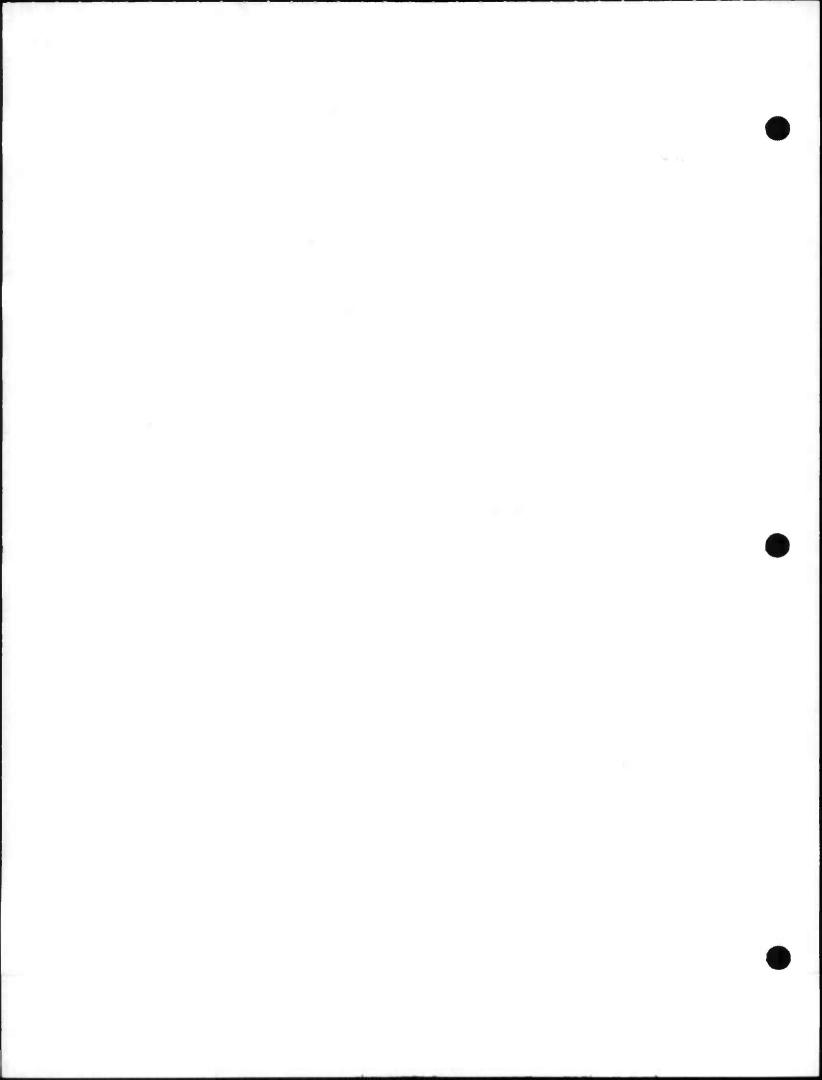
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MAR 3 1 1993



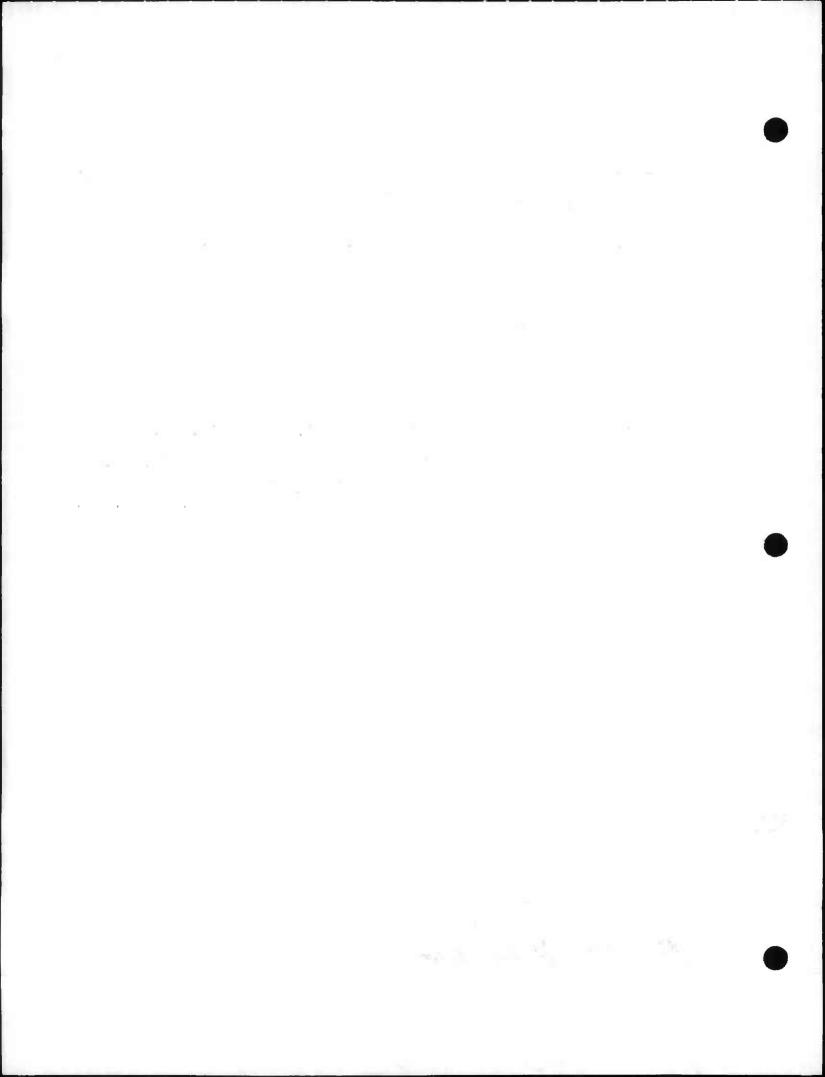
THE MOSTING ON STEWNING FILLSHOWN THE BAY EXPOSED THE WASTERN THE WASTERN THE WASTERN THE MOSTING THE MOST THE	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician and completely filled in the filled within 72 hours after death with the State Dept. of Health and Mental Hydiem prior to burial, crementon, or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
2	10 ad	IMPO

	1 - STATE STATE REGISTRAR	TATE OF MARYL			TMENT ICATE				MENTAI	L HYGIEN			
1	Angela Walters										3. TIME OF DEATH 4:00 Pm		
	220 01 0343	M 2 X F 4	In yrs. las	ISI birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. WONTHS DAYS HOURS MIN.			7. DATE OF BIRTH (Month, Day, Year), 11/14/5/			NY			
DIRECTOR	99. FACILITY NAME (If not institution, give street and number) STELLA MARIS HOSPICE 99. COUNTY O Baltim												
EC	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY			10c. CIT	Y, TOWN OF	LOCAT	ION	_					10d. INSIDE CITY
풉	Maryland Baltim	ore Co		I	Dunda.	lk					LIMITS? 1 YES 2 NO		
JAL.	10e. STREET AND NUMBER			10f. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	2012 Barry Road				21222					USA			
BY FUI	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES				MEO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 X YES 2 NO Specify:					14, RACI Black Spec	E — American Indian, k, White, atc.		
<u>a</u>	15. DECEDENT'S EDUCATION	N .	16e. DE	CEDENT'S	USUAL OC	CUPATIO	ON .		16b.	KIND OF BU	SINESS/IN	DUSTRY	WILLCE
COMPLET	(Specify only highest grade compliance (Specify only highest grade Compliance (Specify (0-12) Col	eted) lege (1-4 or 5 +)	(Gi	ive kind of v Do NOT us	work done du se retired.)	ıring mo	st of worki	ng					
ő	17. FATHER'S NAME (First, Middle, Last)						16. MOT	HER'S NAI	ME (First, A	Aiddle, Maiden	Surname)	-	Gunn
BE	Juan Francisco Acos	ta Rodrigu	ıez				Mar	then.	ia Ja	aquely	n Ac	osta	Rodriguez
5	19. INFORMANT'S NAME (Type/Print)									er, City or Tow		,	
-	Estel Helman		- 6	4 Dr	eyer	Ave	enue,	Stat	en I	sland	, NY	1031	4
	20s. METHOD OF DISPOSITION 1 Burlat 2 Cremation 2 Femoval for			metory or o	OF DISPOSIT ther plece)	ION (Na	me of		DATE	20c. LO	CATION —	City or To	wn, State
	4 Deponetion 4 Other (Specify) 21. SIGNATURE OF FINERAL, SERVICE LICENSE!	1	_		I 00 N	484F A4	D 40005	00.05.54	DIE FERM				
	Monard Wade, Dir State Anatomy Board												
Н	3/29/93 655W.BaltimoreSt,Baltimore,MD 21201 23. FART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
CERTIFICATION	Approximate intervel Between one of dying, such as cardiec or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Inhibition of the condition of the conditions of t												
PHYSICIAN: MEDICAL C	PART II. Other significant conditions con	resulting in the underlying cause given in Part			Part I. 24s. WAS AN AUTOPSY PERFORMED?		246.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
AN	OF THE CASE OFFICE TO THE TANK OF THE TANK												•
Ö		SPITAL:			OTHER:				ock only one				
14S		Inpetient 2 - ER/Outpe 28e. DATE OF INJURY	itlent 3	☐ DOA	4 - Nursin			sidence	_	Other (Specify) HOSPICE DESCRIBE HOW INJURY OCCURED			<u> </u>
	1 Netural 5 Pending	(Month, Day, Year)			URY M	WO	RK?	I NO	26d. DES	CRIBE HOW I	NJURY OC	CURED	
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined						, NO	261, LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLET	29e. CERTIFIER (Check only one) 2												
TO BE C	296. SIGNATURE AND TITLE OF CERPOPIER CALLA LY CLEVALANO D 27087 29c. LICENSE NUMBER D 27087 29d. DATE SIGN 3/2								(Month, Day, Year)				
F	30. NAME AND ADDRESS OF PERSON WHO COM Carla S. Alexander	M.D St	tell	127) (Туре, .a Ma	Print) ris H	osp	ice-	Dula	ney	Valley	r Rd.	-Tow	son 21204
	MAR 31 1993	32, REGISTRAR'S SIGNA	TURE	2.									



STATE	0F	MARYLAND / DEP	ARTMENT OF	HEALTH	AND	MENTAL	HYGIENE
			IFICATE O				REG. NO.

	1 - STATE REGISTRAR	STATE OF MARYL		NT OF HEALTH AND	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH			
	Emma Washing				3 30°	93 YE	M			
	4. SOCIAL SECURITY NUMBER 577-32-2762	1 M 2 F	(In yrs. lest birthday) IF U	IDER 1 YEAR IF UNDER 24 HRS. HS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 8 26	13	Sountry) S . C .			
~	9a. FACILITY NAME (If not institution, give		1.00	CITY, TOWN OR LOCATION OF E	DEATH	9c. COUNTY	OF DEATH			
Ē	Inns of Evergreen Baltimore									
DIRECTOR	10a. STATE 10b. COUNT	Y	10c. CITY, TOV	N OR LOCATION			10d. INSIDE CITY			
	Md .		2525	W. Belvede	re Ave.		1 A YES 2 NO			
FUNERAL	104. STHEET AND NUMBER			101. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?			
S	11. MARITAL STATUS	12. WAS DECEDENT EVER II	N U.S. ARMED	13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Ye	s or No.— 14.	RACE — American Indian,			
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES		If yes, specify Cuban, Mexic	an, Puerto Rican, etc.)		Black, White, etc. Specify: Black			
		l carrow								
ETE	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	le completed)	16a. DECEDENT'S USUA (Give kind of work de life. Do NOT use ratin	L OCCUPATION one during most of worlding old.)	16b. KIND OF BL	ISINESS/INDUST	RY			
IP.	Elementary occordany (0-12)	College (1-4 or 5+)								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use natired.) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)										
TO B	19a. INFORMANT'S NAME (Type/Print)			ESS (Street and Number or Rura	Route Number, City or Tox	vn, State, Zip Coo	le)			
-	Ernest Potee		260 Rol	pert St. D	l Balto.	Md. 2	1217			
	24a: METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ran 4 Donation 5 Other (Specify)	novel from State	netery, crematory or other ple Vestern 5	rosition (Name of Car Cemeter	y 4/2 B	alto.				
	21. SIGNATURE OF FUNERAL SERVICE LI		nevige	22. NAME AND ADDRESS OF F Wainwright	Funeral	Home Balt	o. Md. 2122			
	23. PART I. Enter the diseases, pr	complications that caused. List only one cause on e	d the deeth. Do not er				Approximate			
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)		1	l Nom on			Onset and Death			
	resulting in death) a. Due to (or as a consequence of):									
NO	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):									
AT	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):							
IFIC	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE DF):							
CERTIFICATION	resulting in death) LAST	d								
AL C	PART II. Other significant condition	ns contributing to death b	out not resulting in the	underlying ceuse given in	Part I. 24s. WAS AF	AUTOPSY	24b. WERE AUTOPSY FINDINGS			
호					PERFO	RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE			
MEDIC							OF DEATH?			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ОТЬ	MER:	heck only one)					
14S	1 VES 2 NO	1 Inpatient 2 ER/Outs	patient 3 DOA 4 2	Nursing Home 5 Residence						
	1 Netural 5 Pending	(Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW	INJURY OCCURE	D			
2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number of Rural Route Numb										
								PE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.	
COMPL		ER: On the beals of examination					use(a) and manner as stated.			
BE C	29b. SIGNATURE AND TITLE OF CENTURE		cho	29c. LICENSE NU	MBER	29d. DATE SK	SNED (Month, Day, Year)			
	111000		, ,			18/	31192			
10	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE OF DE		Painte 1	1	1 4-	31193			



1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 93 08663

CERTIFICATE OF DEATH REG. NO. FOR STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH YEAR WAGNER inlet 1850 03 PM 93 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 24 1 - M 2 F Maz page 5 should be detached for use as the burlal-transit permit, Pages 1, 2, 3 should 9a. FACILITY NAME (If not in: 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR RESIDENCE OF 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 301 7000 1 TES 2 NO 10e. STREET AND NUMBER 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 XNO 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES ΒY 3 X Widowed 4 Divorced white COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 8th Lineworker Mfq. notified at once, 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Samuel Edward Ryland unk BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Samuel E. Thomas 1722 Hall Avenue, Lansdowne, Maryland 21227 pe 20e. METHOD OF DISPOSITION

1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20c. LOCATION --- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must director, Druid Ridge Cemetery 4/2/93 | Pikesville, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY completely filled in by the funeral Ambrose Funeral Home, Inc. 1328 Sulphur Spr. Rd. Arbutus, Maryland 21227 the medical 23. PABY I. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata shock, or heart failure. List only one cause on each line. intarvai Batween IMMEDIATE CAUSE (Final Onset and Death disease or condition Respiratory de OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within resulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): and com Obstructue Lung Difeese PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to t If any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to Siec of FAMILER ERRING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 shows any injury, PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS has been signed by the Dept. of Health and M PERFORMED? AVAILABLE PRIOR TO Breagt Comcey COMPLETION OF CAUSE 1 YES 2 NO 1 TYES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE DF DEATH (Check only one) After this certificate I death with the State HOSPITAL:
1 Impatient 2 ER/Outpatient 3 DOA OTHER: 1 TYES 2 NO ng Home 5 - Residence 8 - Other (Specify) 6 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Acciden 5 Pending Investigation BY 1 YES 2 NO Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide DIRECTOR: A hours after de liem 28 is 69 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL D DE filed within 72 ho HOSPITAL 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ST. AGNES HOSTIAL. TOO CATON ALE, BALTO, N.D. 21229 ASVMANI YEBOAH. NO. 32. REGISTRAR'S SIGNATURE in Bernston 1993

	_	_	

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIF

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTMI			MENTAL	HYGIEN REG. NO.	E		
1. DECEDENT'S NAME (First, Middle, Lest)	F. Wi	Itrout			2. DATE O MONTH		28	3	11:35 pm
4. SOCIAL SÉCURITY NUMBER 232-26-1237	5. SEX 6. AGE (n yrs. lest birthdey) IF U 98 YRS. MONT	THIS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, AUG	Day, Year)		Country)	CE (State or Foreign
		inter M	CITY, TOWN OR	LOCATION OF DE	ER	,	9c. COUNTY	OF DEATH	re Co.
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	, Baltimore		WN OR LOCATIO						I. INSIDE CITY LIMITS?
10e. STREET AND NUMBER 2906 Wells A	ve			21219			-		YES 21 TINO
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, spec	NDENT OF HISPAN Ify Cuban, Mexical NO Specify	n, Puerto Ric			RACE -	American Indian, hite, etc.
15. DECEDENT'S EDI (Specify only highest gradi Elementary/Secondary (0-12)	CATION e completed) College (1-4 or 5+)	16a. DECEDENT'S USU/ (Give kind at work a life. Do NOT use retir	done during most		16b. I	CIND OF BU	SINESS/INDUS		
4 th 17. FATHER'S NAME (First, Middle, Last) William Brag	7	nous	T	16. MOTHER'S NAI		ddle, Maiden	Surname)		
19a. INFORMANT'S NAME (Type/Print) Joan Higgs		196. MAILING ADD 2906	Wells				n, State, Zip Co		219
20e, METHOD OF DISPOSITION 1 M Buriel 2 Cremetion 3 Ren 4 Donetion 5 Other (Specify)	noval from Stale	cemetary crematory or of ARDENS	OF FA	ITH	3/3/	BA	CATION — CIT	10 Re	MD.
· Colt	Conne	lly	7110	Solle	rs P	t Rd	Balt	, Mc	undalk 1 21222
23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) Sequentially list conditions,	a. SE DUE TO (OR AS A	A R Y						к,	Approximate Interval Between Onset and Death
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	c	A CONSEQUENCE OF);							
PART II. Other algnificent condition	na contributing to death b	out not resulting in th	na undarlying	cause given in		24a, WAS AN PERFOI 1 YES 2	RMED?	CO DF	RE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				CE OF DEATH (Ch	eck only one)		1	
1 TYES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Out	patient 3 DOA 4		5 Residence		. , ,,			
27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b, TIME OF INJURY	M 1 YE	RY AT IK? ES 2 NO	28d. DESC	CRIBE HOW	INJURY OCCU	RED	
3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spe	/ — At home, farm, street city)	t, factory, office		201. LOCA City o	TION (Street Town, State	and Number or)	Rural Route	e Number,
cont only	BICIAN: To the best of my know IER: On the basis of axemination								d manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIE	E. Pars	un		29c. LICENSE NUI			29d. DATE :	SIGNED (M	onth, Day, Year)
	007 E. Nor			ltimore	e, Ma	aryla	and 2	1214	
31. DATMAR MORPH, 1 1993	Chilipped Manager	Montron							

experience

122 CT21 NVF

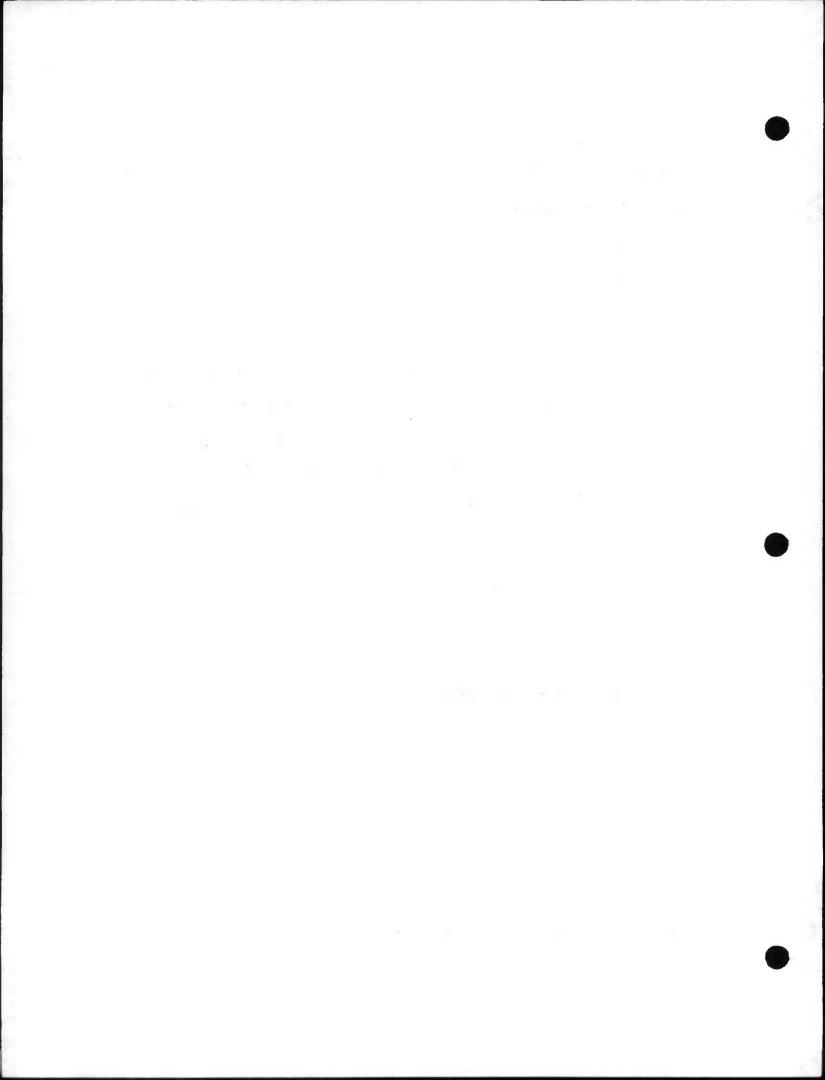
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tilds a promidled and alle that the section of the

SERVE OF AN AN AN AN AN AN AN ANALYSIS CITY

MINISTON OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARKIAND 21215-0020	
IR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by Tell physician,	
PRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shows the marked for use as the burial-transit permit. Pages 1, 2, 3 should have been with the State Debt. of Health and Mental Hydlere prior to burial, committing.	es 1, 2, 3 should
em 28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1. DECEGENT'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY		3. TIME OF DEATH
	Robert Owen Weller			3 27	93	1:30 A.
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. les	birthday) IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)	8. BIRT Coun	HPLACE (State or Foreign
		3 YRS.	117	4/19/39		ew Jersey
	9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN	R LOCATION OF DEAT	TH 9	c. COUNTY OF	DEATN
CTOR	St. Joseph's Hospital		Towson			Balto.
REC	10s. STATE 10b. COUNTY	10c. CITY, TOWN OR LOCA	ION			10d. INSIDE CITY
ä	Maryland Balto.	Timoniu	n			LIMITS? 1 YES 2 NO
AL	10e. STREET AND NUMBER		ZIP COOE	-10	Og. CITIZEN OF	WHAT COUNTRY?
FUNER	211 Purlington Rd.		21093			U.S.A.
Ξ	11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2 MARRIED	MED 13. WAS DEC	ENOENT OF NISPANIC	ORIGIN? (Specify Yea or Puerto Rican, etc.)	No — 14. RAC Blac	E - American Indian, ck, White, etc.
BY	3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES		2 NO Specify:		Spec	olfy:
ED	15. OECEDENT'S EQUICATION 15e. DE	CEDENT'S USUAL OCCUPATION	IN .	16b. KIND OF BUSINE	ESS/IND/JETDY	White
<u> </u>	(Specify only highest grade completed) (Gi	ve kind of work done during mo Do NOT use retired.)		IOS. KIND OF BOSINE	ESS/INDUSTRI	
릴		eting Servic	Mar	Cummins C	hecane	ake Ind
COMPL	17. FATNER'S NAME (First, Middle, Last)	TELLIG DELVIC		E (First, Middle, Maiden Sun		are Inc.
ш	Charles Weller		Katha	rine Owe	n	
TO B	19a. INFORMANT'S NAME (Type/Print) 19t	. MAILING ADORESS (Street a				
-	Mrs. Laura O. Weller	Same	as 10e			
		ND DATE OF DISPOSITION (Na matory or other place)	me of	OATE 20c. LOCAT	ION — City or T	own, State
l I		op Service C			son ,	Maryland
1	2. SIGNATURE DE TONENAL SERVICE LICENSEE	22. NAME A	D ADDRESS OF FACIL	uny 1050 York R	27.2	0.4
	Mongell Chilister fr.	Ruck '		neral Home,		04
	23. PART I. Enter the diseases, or complications that caused the de ahock, or heart fallurs. List only one cause on each line	ath. Do not entar the mo	de of dying, auch	as cardiac or reapirate	ory erreat,	Approximate
	IMMEDIATE CAUSE (Final					Interval Betwee
	disease or condition Cardiac a	rrest				
	OUE TO (OR AS A CONSEC					
NO NO	Sequentially list conditions, D. Cardiomyon					1 mc
AT	If any, leading to immediate cause. Enter UNDERLYING	UENCE OF):				
윤	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF AS A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF A CONSECUTION OF	UENCE OF):				
CERTIFICATION	resulting in death) LAST					
	PART II Other elgoifficent conditions contribution to double to					
SAL	PART II. Other significant conditions contributing to death but not re	esulting in the underlying	cause given in Pa	ert i. 24a. WAS AN AUT PERFORME		. WERE AUTOPSY FINDING AVAILABLE PRIOR TO
EDIC	Charcot-Marie Tooth disease			1 □ YES 2 💢	NO	OF DEATH?
₹				-		1 TYES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	of Di	105.05.05.1711.00			
PHYSICIAN	EXAMINER? 1 YES 2 NO	OTHER:	ACE OF DEATH (Check			
Ě	27. MANNER OF DEATH 28e. DATE OF INJURY	28b. TIME OF 28c. INJ	5 ☐ Residence 6	Other (Specify)	BY OCCUBED	
	1 Natural 5 Pending (Month, Day, Year)	INJURY WO	RK?	DECOMINE NOW INJU	VVVVNEU	
р ву	2 Accident Investigation 3 Suicide 6 Could not be building str (Specific)			81. LOCATION (Street and i	Number or Rural	Route Number.
H	4 Homicide determined building, etc. (Specify)			City or Town, State)		
J.	29s. CERTIFIER (Check only CERTIFYING PNYSICIAN: To the best of my knowledge, der	th occurred at the time date	and place, and due to	the council and	an ateta d	
COMPLE	(Check only one) 2 MEDICAL EXAMINER: On the basis of my knowledge, determined one of the basis of my knowledge, determined one of the basis of the					e) and manner as stated.
- 1	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBI			(Morth, Day, Year)
m I	May ld Ougue		DIII	74 1	3/20	(MONTH, Day, Year)
8		1970 (Fee Orien)	21111		3/27	17)
TO B	30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM	(rype, Print)		•		
			193	·	('	
	Donald Wood M.D. 2 Greenmeador 31. DATE FILE? (Aunth, Day, Year) MAR 3 1 1993 32 REGISTRAR'S SIGNATURE		093			



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	BALTIMORE, MARYLAND 212/5-0020
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or menuments.	ours after death. Page 6 may be retained by the hospital or menume promisian.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use at the permitten and Martal Humane prior to build compared on removed.	I in by the funeral director, page 5 should be detached for use as me before trans
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	medical examiner must be notified at once.

Pages 1, 2, 3 should

permit.

DIRECTOR

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CERTIFICATION

MEDICAL

PHYSICIAN:

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WHO COMPLETED CAUSE OF

1 1993

32 REGISTRAP'S SIGNATURE
from Devidson Pandelle

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 93 08666 1 CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR CATHARINE M. ZIMMERMAN 7:30 a 3-28-93 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 171-50-6497 DAYS HOURS 1 M 2 X F 89 7-2-03 Pennsylvania 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 4 Horseshoe Cir. Lutherville Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore 1 YES 2X NO Lutherville 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4 Horseshoe Cir. 21093 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—It yes, specify Cuben, Mexican, Puerto Rican, stc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, stc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES Specify: 3 🔀 Widowed 4 🗌 Divorced White 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Housewife Own Home 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surname) John Russell Libhart Catharine 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myers Funeral Home 37 E. Main St. Mechanicsburg.Pa 17055 20e. METHOD OF DISPOSITION
1 № Buriel 2 □ Cremation 3 ☒ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State stery, crematory or other place)
Rolling Green Cemetery 3+31-93Lower Allentownship, Pa 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SEBURCE LICENSEE 22. NAME AND AGORESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23. PART I. Enter the diseases, or complications that ceused the daeth. Do not enter the moda of dying, such as cardiac or respiratory arrest, Approximete ahock, or haart failure. List only one cause on aech fine Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediata cause. Enter UNDERLYING CAUSE (Disesse or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAIL ARLE PL COMPLETION OF CAUSE OF DEATH? 1 YES 2 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) EXAMINER! HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF BEATH 28e. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF 28c. INJURY AT WORK? 1 Natural 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town. State) 3 Suicide 6 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 [MEDICAL EXAMINER: On the heats of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. ANO TITLE OF CERTIF 29d. DATE SIGNED (Month, Day, Year) in

 BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

TO HE MINERAL PRECIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be the complete that the state of t

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR

1 - STATE REGISTRAR		OTHE OF I	C	ERTIF	ICATE O	F DEATH	MENIA	REG. NO			
1. DECEDENT'S NAME (First,	Middle, Last)							OF DEATH			3. TIME OF DEATH
SAMUEL	BRUCE	ABR	UTYN				MARC	H 12,	1993	YEAR	8:250
4. SOCIAL SECURITY NUME	ER !	5. SEX	6. AGE (In yrs. I	last birthday)	IF UNDER 1 YEAR		7. DATE	OF BIRTH	1773	8. BIRTH	PLACE (State or Foreign
157-09-975	3	1 XM 2 - F	82	YRS.	MONTHS DAYS	HOURS MIN.	9 _	25 -	1910	Country	NEW JERSEY
9a. FACILITY NAME (# not in	stitution, give stree	et and number)			9b. CITY, TOWN	OR LOCATION OF		23		NTY OF O	
SUBURBA	N HOSPI	TAL		Į	E	ETHESDA					OMERY
RESIDENCE OF DEC											OTIBICE .
10a. STATE	10b. COUNTY				r, TOWN OR LOC						10d. INSIDE CITY LIMITS?
MARYLAND	МО	NTGOMER'	Υ	RO	CKVILLE						1 X YES 2 NO
100. STREET AND NUMBER 5901 M	OMEDOCE	DOAD	#wana			et. ZIP CODE			10g. CIT	ZEN OF W	HAT COUNTRY?
	ONTROSE	ROAD	FNZUZ			20852			UNIT	ED S	TATES
11. MARITAL STATUS 1 Never Married 2 X		2. WAS DECEDEN	T EVER IN U.S. A	RMED	13. WAS DI	CENDENT OF HISP/ specify Cuban, Maxk	ANIC ORIGI	17 (Specify Ye	a or No-	14. RACE	American Indian, , Whita, atc.
3 Widowed 4 Divo	- 10111	IF YES, OIVE W	AR OR DATES		1 🗀 YE	S 2 X NO Spec	ify:	Hican, atc.)		Specif	y:
											WHITE
(Specify only	EDENT'S EDUCAT highest grade coi	mpleted)	18a, E	Give kind of w	USUAL OCCUPAT rork done during r e retired.)	TION nost of working	16k	. KIND OF BU	SINESS/INC	USTRY	
Elementary/Secondary (0	-12)	College (1-4 or 5+	,								
17. FATHER'S NAME (First, MI	4.00	4	A	TTORN	EY/OWNE			TEDICA:		PLY	STORE
						18, MOTHER'S N	AME (First,	Widdle, Maiden	Sumame)		
ELIAS ABRU							(UNK				
	,			9b. MAILING	ADDRESS (Street	and Number or Rura	Route Num	ber, City or Tow	m, State, Zip	Code)	
EVA HONIGBI	ERG ABRI	UTYN (W	(FE) 5	901 M	ONTROSE	RD. #N2	02. R	OCKVII	LE.	MD :	20852
209. METHOD OF DISPOSITI	ON n 3 □ Ramova	il from State	20b. PLACE	E AND DATE O	F DISPOSITION (lame of	OAT		CATION -		vn, Stata
4 Donation 5 Other	Specify)				ORIAL G	ARDENS	i	0	LNEY,	MAR	YLAND
21. SAGNATURE OF FUNERAL						NO ADDRESS OF F		MEMO	DTAT	OHAD	ET C THO
tas	ch (2/4	sel								ELS, INC.
23. PART I. Enter the dis	seases, or con	notications that	caused the d	leath Don	of enter the m	RUCKVILL	E PIR	<u>E - R</u>	OCKVI	و تابابا.	MARYLAND
enock, or ne	ert reliure. Lis	t only one ceu	ne on each iin	ie.	or enter the th	ode of dying, su	cn se cert	lisc or respi	iratory arr	est,	Approximate Interval Between
iMMEDIATE CAUSE (Fin- disease or condition		1.	6	11	11000	1-0 11					Onset and Deeth
resulting in death)	e	Cener	RAL	11	2011	na be	110	PEN.			100xs
		AL	OR AS A CONSI	EUDENCE OF	· / - ·	Iln h		,			10.11.
Sequentially list condition		OUE TO	OR AS A CONSE			111/1					10 years
if any, leading to immed cause. Enter UNDERLY!!	NG				r						
CAUSE (Disease or Injur	у 🕻 с	DUE TO (OR AS A CONSE	EOUENCE OF):						
reaulting in death) LAST					•						İ
	d										+
PART II. Other eignificer	t conditione c	ontributing to	death but not	resulting in	the underlyli	ng ceuse given in	Part I.	24a. WAS AN			WERE AUTOPSY FINDINGS
								PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
								1 123 2	, in		OF OEATH?
											1 YES 2 NO
25. WAS CASE REFERRED TO	MEOICAL				28. F	LACE OF DEATH (C	heck only on	e)			
EXAMINER? 1 YES 2 NO	5	OSPITAL:	ER/Outpatient		OTHER:						
27. MANNER OF OEATH		28a. DATE OF	NJURY	28b. TIME	-	ne 5 🗆 Rasidence		CRIBE HOW II	M HURY OCC	HIBED	
(-	ending	(Month, Da	y, Year)	INJU	IRY W	YES 2 NO	LOU. DEG	OMBE NOW II	NJOH! OCC	UNED	
3 Suisido	ivestigation	28a, PLACE OF	INJURY - At h	ome farm st	reet, factory, offi	-	204 1 00	ATION (Street a	and March		
	ould not be etermined	building, a	tc. (Specify)		read readerly, orn		City	or Town, State)	ina number	or Hurai Ho	oute Number,
29a. CERTIFIER					-						
(Check only one)	EVALUATION	N: To the best of r	ny knowledge, d	eath occurred	f at the time, dat	a and place, and du	to the cau	se(a) and man	iner aa atate	id,	
177		III the peals of axi	mination and/or	Investigation	, in my opinion,	death occured at the	time, data	and place, an	d due to the	cause(a)	and manner as stated.
296. SIGNATURE AND TITLE	OF CERTIFIER	7 , 1	8			29c. LICENSE NU	MBER		29d. DATE	signed (Month, Oge Wars
1/1/1	11 /	All	11	0		1138	18		13	//2	2/93
30. NAME AND ADDRESS OF	ERSON WHO C	OMPLETED CAUSE	OF DEATH (ITE	EM 27) (Type, I	Print)				-/	-	//-
/											
31. OATE FILED (Month, Day, Y	ear)	32. REGISTRAR	'S SIGNATURE								
MAR 16 '0	3	Lika Day		ndo 82							

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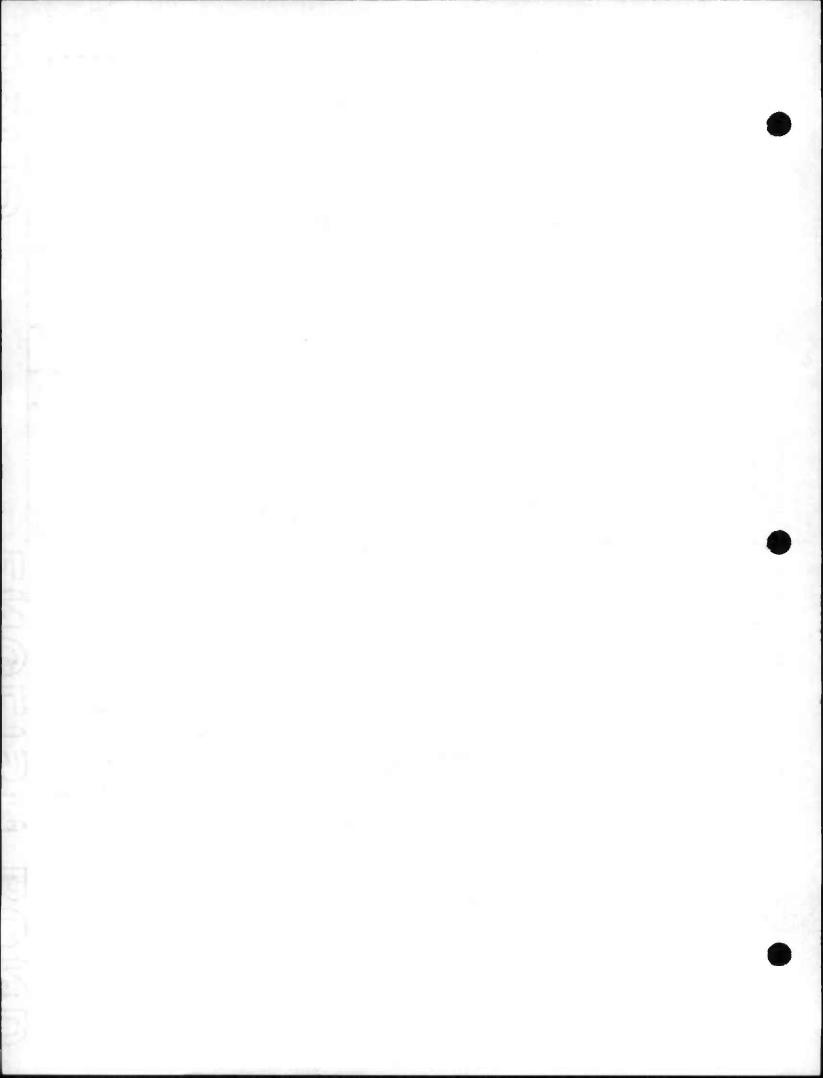
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BALLIMONE,	24 hours after death, Page 6 may be	/ filled in by the funeral director, page tion, or removal.	the medical examiner must be
DIVISION OF VITAL NECONDS, F.O. BOA 667 60,	IN THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page had within 72 hours after death with the State Deor, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be
4	100	22	· =

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH MONTH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR Duignan 1993 Rita March 8:00 A. Arroyo 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER I YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 M 2 X F 298-01-4445 76 May 20, 1916 Ohio 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Springbrook Adventist Nursing Home Silver Spring Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 NO MD Montgomery Germantown 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 10f. ZIP CODE 13225 U.S.A. Whitechurch Circle 20874 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. yes, specify Cuban, Mexican, Puerto Ri FORCES? 1 YES 2 XNO 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TYES 2 X NO Specify: Specify: BY 3 🔀 Widowed 4 🗌 Divorced White ETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Clerk Federal Government 17. FATHER'S NAME (First, Middle Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Thomas Duignan Catherine L. Lonergan BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 13225 Whitechurch Circle, Thomas Arroyo Germantown, MD. 20874 20a. METHOD OF DISPOSITION 20b. PLACE ANO DATE OF DISPOSITION (Nam. DATE 20c. LOCATION - City or Town, State 1 X Buriel 2 Cremelion 3 Removal from State of cemetary, crematory or other piace)
Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 3/17 Silver Spring, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY DeVol Funeral Home 10 E.Deer Park Dr., Gaithersburg, MD. 20877 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, **Approximeta** shock, or haart fallure. List only one cause on each line. Interval Between **Onset and Death IMMEDIATE CAUSE (Final** disease or condition reaulting in death) Metastatic Colon Cancer Months **OUE TO (OR AS A CONSEQUENCE OF)** CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING **CAUSE** (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE Alzheimer's Disease 1 TYES 2 X NO OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) or Item HOSPITAL: OTHER:
4 (X Nursing Home 5 | Realdence 8 | Other (Specify) 1 YES 2 NO tient 2 - ER/Outpatient 3 - DOA 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY marked, 5 Pending 1 🔀 Netural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide ED 8 Could not be 4 Homicide COMPLET 29a. CERTIFIER 1 📉 CERTIFYING PHYSICIAN: To like best of my knowledge, deeth occurred at like lims, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 29b. SICHAPURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D08089 March 15, 1993 2 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 11120 New Hampshire Ave., Silver Spring, MD. 20904 Michael E. Leibowitz, 31. DATE FILED (Month, Day, Year)
MAR 19 '9 32. REGISTRAR'S SIGNATURE chia Davidson Randelle '93



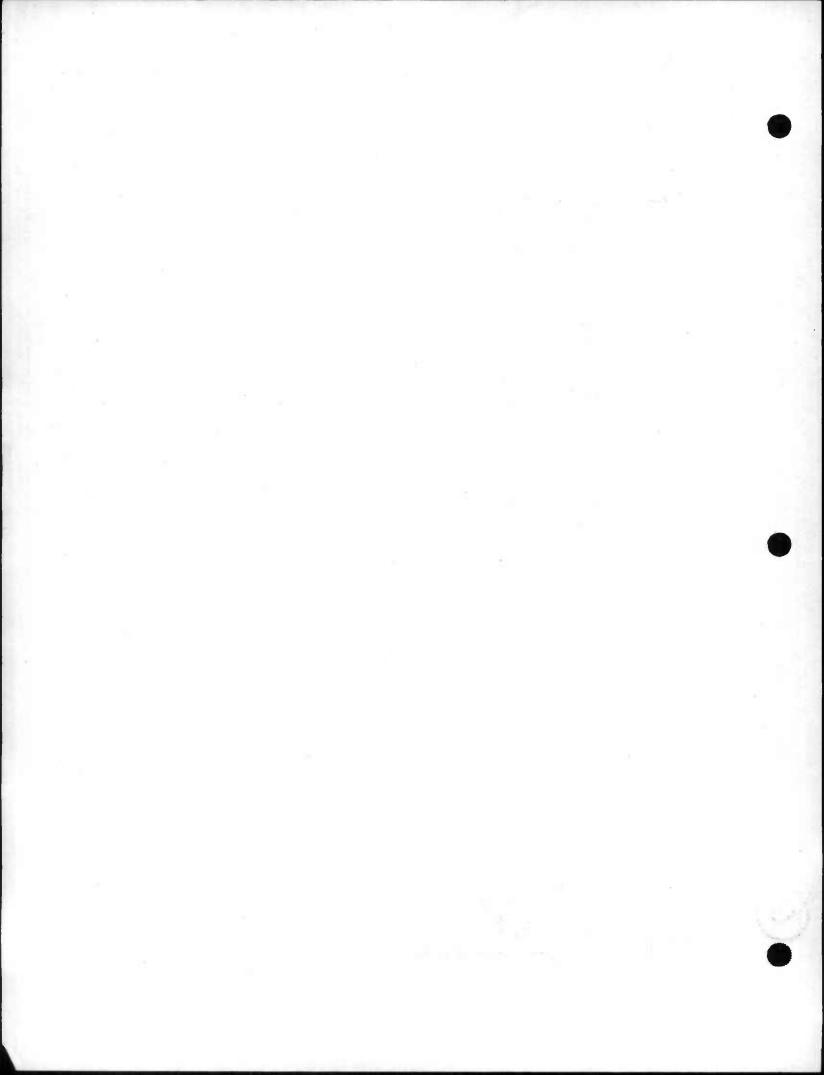
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TO BE COMPLETED BY FUNERAL DIRECTOR

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	FOR STATE REGISTRAR	STATE OF MARYL			F HEALTH AND		IENE -	33 (18669
	1. DECEDENT'S NAME (First, Middle, Lest) ADDIE	AI	KEN			2. DATE OF DEA MONTH 5-9:	TH DAY	VEAD	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YE		7. DATE OF BIRT (Month, Day, Ye		8. BIRTNPLA Country)	ACE (State or Foreign
	577-32-8342 90. FACILITY NAME (If not institution, give s:	1 M 2 X F 7	9 YRS.		WN OR LOCATION OF DI	DEC. 2	0, 1913		ine Co. VA.
OR	7425 Parkwood S				ver Hills				eorges
EG	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	Y	10c. CI	Y, TOWN OR L	OCATION			10	d. INSIDE CITY
DIRECTOR			Wa	shingt	on, D.C.			1)	LIMITS?
AL	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CIT	ZEN DF WNA	T COUNTRY?
FUNERAL	1200 Delaware Av	enue, S.W.	#220		20032		Uni	ted St	tates
5	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	N U.S. ARMED		DECENDENT OF HISPAI s, specify Cuben, Mexica			14. RACE — Black, W	American Indian, hite, atc.
Β×	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 []	YES 2 NO Specif	y:		Specify:	lack
	15. DECEDENT'S EDU	CATION	16e. DECEDENT'S	USUAL OCCU	PATION g most of working	16b. KIND C	F BUSINESS/INI		
E I	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT L	ise retired.)					
COMPLETED	Unknow		Domest	ic Wor			undry		
	17. FATNER'S NAME (First, Middle, Last) Willie Thomas W	orm1 orr				ME (First, Middle, N			
BE	19e. INFORMANT'S NAME (Type/Print)	ormiey	105 MAIL IN	ADDRESS (St	LUVEN]	la Washi		Code)	
2	Agnus Dua				od St. Lar				785
	20e. METNOD OF DISPOSITION	200	b. PLACE OF DISPO		of cemetery, cremetory or		Bc. LOCATION —	_	
	Burial 2 Cremation 3 Rem Donation 5 Other (Specify)	oval from State	other place) Cedar H	ill Ce	metery		Suitlan	d, MD	
	21, SIGNATURE OF BUNERAL SERVICE LIC	CENSEE	_	22. NAN	E AND ADDRESS OF FA	CILITY			
	· alley s	. Pope	n.		2617 Pa. A				
	23. PART i. Enter the diseases, or a	complications that cause List only one cause on a		not enter the	mode of dying, suc	ch ea cardiec or	respiratory er	rest,	Approximate interval Between
	IMMEDIATE CAUSE (Final	clat only one cease on e	ech me.						Onset and Death
	disease or condition resulting in death)	. Malignant	Lymphom	а					1 Year
		DUE TO (QR AS	A CONSEQUENCE I)F):					
ON	Sequentially list conditions,	b DUE TO (OR AS .	A CONSEQUENCE (OF):					
CERTIFICATION	if any, leading to immediate ceuse. Enter UNDERLYING								!
Ĕ	CAUSE (Disease or injury thet initieted events	DUE TO (OR AS	A CONSEQUENCE (P):					
ERI	resulting in deeth) LAST	d							
AL C	PART ii. Other aignificant condition	ne contributing to death i	but not recuiting	in the under	tying ceuse given in		AS AN AUTOPSY		ERE AUTOPSY FINDINGS
S							ERFORMED?	C	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
MEDIC								- 1	YES 2 NO
PHYSICIAN: M									
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	6. PLACE OF DEATH (C	heck only one)			
IYS	1 TYES 2 NO	1 Inpatient 2 ER/Out 28a. DATE OF INJURY	patient 3 DOA	4 - Nursing	Nome 5 (X Residence	e Other (Special 26d. DESCRIBE		CUBED	
	1 Natural 5 Pending	(Month, Day, Year)	200. 11	JURY	WORK?	200. DESCRIBE	NDW INJURY OC	CORED	
ВУ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJUR	Y — At home, farm,				Street and Numbe	r or Rural Rou	te Number,
빌	4 Nomicide determined	building, atc. (Spe	ecity)			City or Yown,	, State)		
COMPLETED	29e. CERTIFIER 1 CERTIFYING PNYS	ICIAN: To the best of my know	viedge, death occur	red at the time,	date end place, end du	e to the cause(a) a	nd manner as sta	nted.	
MO	anal	ER: On the basis of examination							nd manner se stated.
	250. SIGNATURE AND TITLE OF CERTIFIE	fi)			29c. LICENSE NU	MBER	29d. DA	TE SIGNED (M	Ionth, Day, Year)
O BE	Deved of	Jerry			1856	1	► E	3/5/	93
٩	30. NAME AND ADDRESS OF PERSON WE David J. Perry, l	//			., 2A-38,	Washingt	on D.C	. 200	10
	31. PATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG		-,	-,,		2.0	- 200	
	MARU 8 1993	Lucia Savidson 7							



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JS, P.O. BOX 6876 0	to death cardificate he exercited within 24 hours offer death Dans & man he are

IARYLAND 21215-0020 DIMSION OF VITAL RECORD

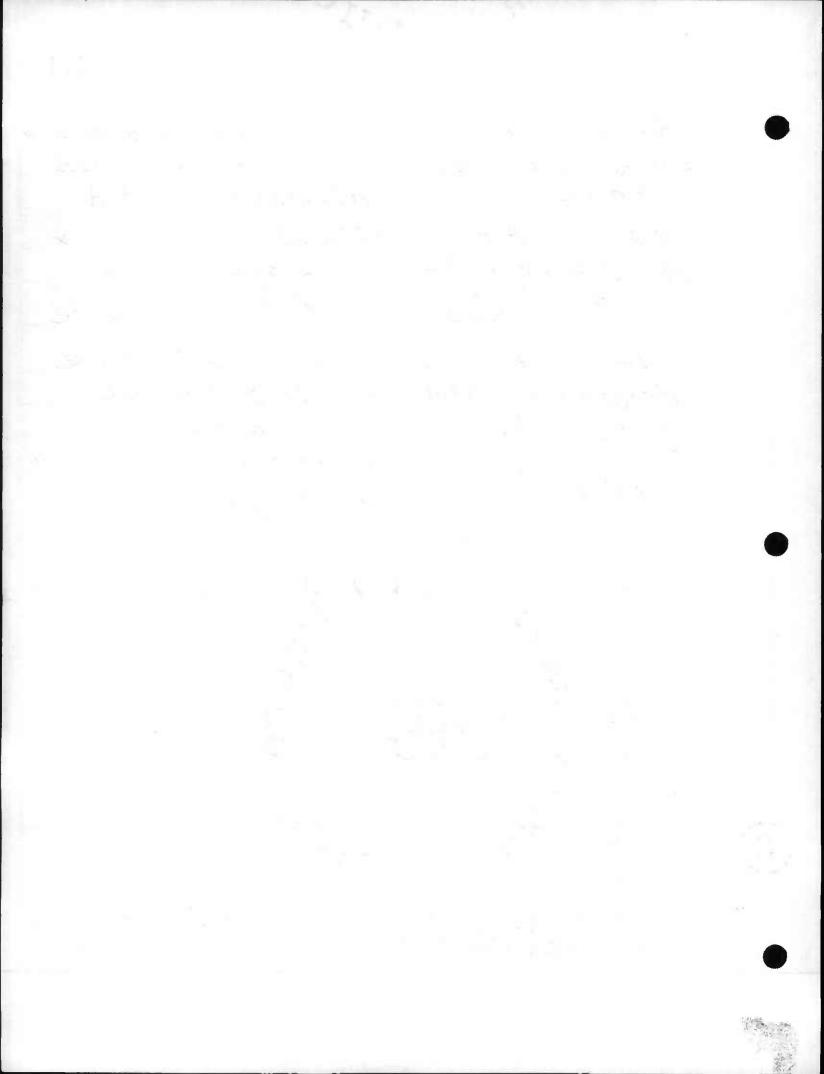
		FOR 1 STATE		STATE OF N	MARYLAN	D / DEPAR	RTMENT O	F HI	EALTH AND	MENT	AL HYGIEN	9 3	08670	
		1. DECEDENT'S NAME (First	t, Middle, Lest)		7	CERTIF	ICATE (<u>OF</u>	DEATH	MOR			3. TIME OF DEATH	
_		Hoover 4. social security number 249 94 13		5. SEX		Adams rs. last birthday) YRS.	IF UNDER 1 YE MONTHS DA	EAR AYS	IF UNDER 24 HRS. HOURS MIN.	7. DAT	13 05 E OF BIRTH onth, Day, Year) 16,195	6	93 1702 BIRTHPLACE (State or Foreign SOUTH (ARO)	m LII
2, 3 should	CTOR	96. FACILITY NAME (II not in			al Cr	ıtr.	100		R LOCATION OF DE			9c. COUNT	of DEATH	13
. Pages 1,	MD PRINCE GEORGES 10c. CITY, TOWN OR LOCATION LANDOVER, MD								10d. INSIDE CITY LIMITS? 11 YES 2 NO					
prysician. bunal-transit permit.	ERAL	100. STREET AND NUMBER 8942 CONG		PL				10f.	ZIP COOE 20785			10g. CITIZE	N OF WHAT COUNTRY?	
를 를	BY FUNI	11. MARITAL STATUS 1 Never Married 2 3 3 Wildowed 4 Divo		12. WAS OECEDEN FORCES? 1 IF YES, GIVE W	YES 2	□ BO	If ye	s, spec	NDENT OF HISPAR city Cuban, Mexica 2 X NO Specifi	in, Puert		or No—	Black, White, etc. Specify: BLACK	
for m	PLETED	15. DEC (Specify on Elementary/Secondary (I	y highest grade	CATION completed) College (1-4 or 5 + 2	+)	Give kind of the Do NOT us	work done durin se retired.)	ng most	t of working	10	GOVER		тяу	
be det	BE COMPL	17. FATHER'S NAME (First, A HOOVER	ADAMS						18. MOTHER'S NA MILDE	RED	, Middle, Malden IVEY	Surname)		
be notified	10	190. INFORMANT'S NAME (I	AMS			8942	CONG	RE	d Number or Rural I	ANI	mber, City or Town DOVER ,	n, State, Zip Co MD	ode)	
director, pa		20a. METHOD OF DISPOSIT During 2 Crematic Donation 5 Other	(Specify)		20b. PL/ cemeter CE	DAR H	ther place)			3/1			y or Town, State LAND, MD	
by the funeral director, page smoval. Ilical examiner must be		1 Cae	PLO	E Nu	llin	~	RAL 517	PH 1	WILLIA 1th STI	AMS REE'	T S.E.			
completely filled in by the ial, cremation, or removal cevent, the medical		23. PART I. Enter the d ahock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in deeth)	eart fellure. I nel	omplications the	ise on eech	line.			А	h aa ce	erdiec or respi	ratory arrea	t, Approximete interval Betw Onset and De	rean
ending physician and I Hygiene prior to but or other traumath	ERTIFICATION	Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inju- that initiated events resulting in death) LAS	lons, dlate ING iry	OUE TO	(OR AS A CO	NSEQUENCE OF	ት):							
en signed by the of Health and Me	MEDICAL C	PART II. Other significe	ent condition	e contributing to	death but r	not resulting	In the under	lying	cause given in	Part I.	24a. WAS AN PERFOR 1 VES 2	MED?	24b. WERE AUTOPSY FINDI AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO	
cate has be State Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:			OTHER:	6. PLA	CE OF DEATH (Ch	eck only	one)			
at sertific the the S	PHYS	1 X YES 2 NO 27. MANNER OF DEATH	200000	1 Inpatient 2 2 28e. DATE OF (Month, De	INJURY	28b. TIM	4 Nursing	Home : INJU	5 Residence		her (Specify) ESCRIBE HOW IP	JURY OCCUP	RED	_
Atter or death	ED BY	2 Accident 3 Suicide 6	Pending Investigation Could not be determined	bunding,		At home, farm, s	<u> </u>	Office		26f. LC	CATION (Street a by or Town, State)	nd Number or	on subject	
MIT IT NEW 28	COMPLET			CIAN: To the best of	my knowledge	e, death occurre			nd place, and due		euse(e) end man	ner ee stated.	Place	d.
TO THE FUNE be filed	то ве с	296. SENATURE AND TITLE	he	This					29c. LICENSE NUN	MF.		29d. DATE S	MGNED (Month, Day, Year)	
7		Margarita 31. DATE FILED (Month, Day, MAR ()	a A. K	orell.	MD		000 0	tr	eet, B	alt	imore,	Mar	vland 212	01

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FOR 1 - STATE

,		REGISTRAR	CERTIFI	CATE OF DEATH	REG. NO.	
		1. DECEMENT'S NAME (First, Middle, Last)			2. DATE OF DEATH 35 MONTH 33 DAY	year 93 2006 •
P		524-26-9669	SEX 6. AGE (In yrs. last birthday) M 2 F	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
, 2, 3 should	СТОВ	99. FACILITY NAME (If not institution, give street A A C RESIDENCE OF DECEDENT	and number)	9b. CITY, TOWN OR LOCATION OF DE	LUS 9c. COI	INTY OF DEATH
permit. Pages 1,	DIRE	10e. STATE 10b. COUNTY	A .A . 10c. CTT	ARNO W		10d, INSIDE CITY LIMITS? 1 YES 2 TO NO
St	NERAL	100. STREET AND NUMBER 141 SPRIN		101. ZIP CODE	/) (10g. CIT	SA
ing physician. the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 □ YES 2 □ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPAN If yes, specify Cuben, Mexics 1 YES 2 SCNO Specify		14. RACE — American Indian, Black, White, etc. Specify:
nous are leads. Rage o may be retained by the hospital of attending prysician ed in by the funeral director, page 5 should be detached for use as the buriat-train, or removal. Indedical examiner must be notified at once.	LETED	15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12)	ON 16a, DECEDENT'S	USUAL OCCUPATION work done during most of working e retired.)	166. KIND OF BUSINESS/IN	DUSTRY
ine nospin detached t once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	4 Ene	18. MOTHER'S NA	ME (First, Middle, Melden Surname)	ghouse
5 should be	TO BE	10a. INFORMANT'S NAME (Type/Print)	A M 19b. MAILING	ADDRESS (Street and Number or Rural I	Soute Number, City or Town, State, Z	ITER (p Code)
ector, page (20s. METHOD OF DISPOSITION 1 Method 2 Cremation 3 Removal 4 Donation 6 Other (Specify)			DATE 20c. LOCATION -	- City or Town, State - City or Town, State - City or Town, State - City or Town, State
three director, in the complete of the complet		21. SIGNATURE OF PUMERAL SERVICE LICENS		22. NAME AND ADDRESS OF FAI		PARK F.H
d in by the or removal.		23. PART I. Enter the diseases, or com	plications that caused the death. Do n	ot enter the mode of dying, suc	700	
		shock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death) a	a only one cause on each line.	ARREST		Interval Between Onset and Death
to burial,	ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF	CARCINDONA	of Esoph	20mps 200
ending physical property of other	CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (DR AS A CONSEQUENCE OF):		
the after d Mental Injury, c		PART II. Other aignificant conditions c	ontributing to death but not resulting in	n the underlying cause given in	Part I. 24s. WAS AN AUTOPSY	
igned by lealth an	MEDICAL	ESOPUTION	CIRRITOSIS	>	PERFORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
has been Dept. of 23 shc		MACIGNA	NT ASCITES			
cattern has been Dept. of 1, or Item 23 sho	SICIAN:		OSPITAL: Inpatient 2 ER/Outpatient 3 DOA	26. PLACE OF DEATH (Chi		
d, or	PHYS	27, MANNER OF DEATH	26s. DATE OF NJURY 28b. TIME	4 Nursing Home 5 Residence E OF 28c. INJURY AT	28d. DESCRIBE HOW INJURY OF	CURED
After this death with	BY F	Netural 5 Pending Investigation	(Month, Day, Year) INJI	M 1 YES 2 NO		
CTOR: A after di 28 Is	ETED !	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — At home, farm, a building, etc. (Specify)	treet, factory, office	261. LOCATION (Street and Number City or Town, State)	or or Burel Boute Number,
MT: If Item	COMPLI		Y: To the best of my knowledge, death occurre on the bests of examination and/or investigation			
TO THE PER PER PER PER PER PER PER PER PER PE	TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIED	are Mi)	290 LICENSE NUM	196 A 29d. DA	TE SIGNED (Month, Day, Year)
	ř	30. NAME AND ADDRESS OF PERSON WHO C	SARE MIDO	Print) BESTBAF	E BD#30	2 ANNAPORCS
		31. DATE FILED (MONTH, Day, Year) MAR 1 8 1993	Juna Davidson-Kondale		14.4	021401



30, NAME AND ADDRESS OF MERSON W Ritchie Riehie Shoemaker,

5 1993

31. DATE FILED (Month, Day, Year)

MAR

6

ERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAN'S SIGNATURE

MD - 1604 Market street, Pocomoke, Md.

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retained	5 should		notified
may be	or, page		net ha
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tter death	the fune	Oval	neva is
hours a	lled in by	n, or rem	madic
within 24	pletely fi	cremation	ant the
pecruted	апд сош	bunal,	natic ou
cate be	hysician	prior to	חוובין זו
In certific	ending p	II Hygien	or other
The dea	ny the aff	nd Menta	Inim
uires that	signed t	Health a	WE SHY
e law req	has been	Dept. of	23 she
MYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicit	ertificate	the State	or item
G PHYS	er this co	ath with 1	narked
HOSPITAL OR ALLENOING PHYSIC	FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, gage 5 should be detached for use as the burial-transf nermin panes 1 2 3 cay	within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	TANT If item 28 is marked or item 23 shows any injury or other traumatic exent the medical examiner must be notified at once.
AL UK A	AL DIREC	72 hours	if item
HOSE	FUNER.	within	TANT

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH 3. TIME OF OFATH 1993 Joseph B. Asanovich 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year) DAYS 1 🔯 M 2 🗌 F MONTHS HOURS MIN. 057/32/5918 YRS. 52 /19/1941 New York 9a. FACILITY NAME (If not institution, give street and number) 9h. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR 4989 Shelltown Road Shelltown Marion Somerset 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Somerset Marion 1 TES 2 1 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10a CITIZEN OF WHAT COUNTRY? 4989 Shelltown Road 21838 USA 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 200 Merried ВУ Specify: 3 Widowed 4 Divorced 5/23/60-2/28/63 white COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 charter boat captain 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Bruno Asanovich BE Mary Misiaszek 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Barbara Asanovich 1989 Shelltown Rd., Marion, 21838 Md. 20a. METHOD OF DISPOSITION

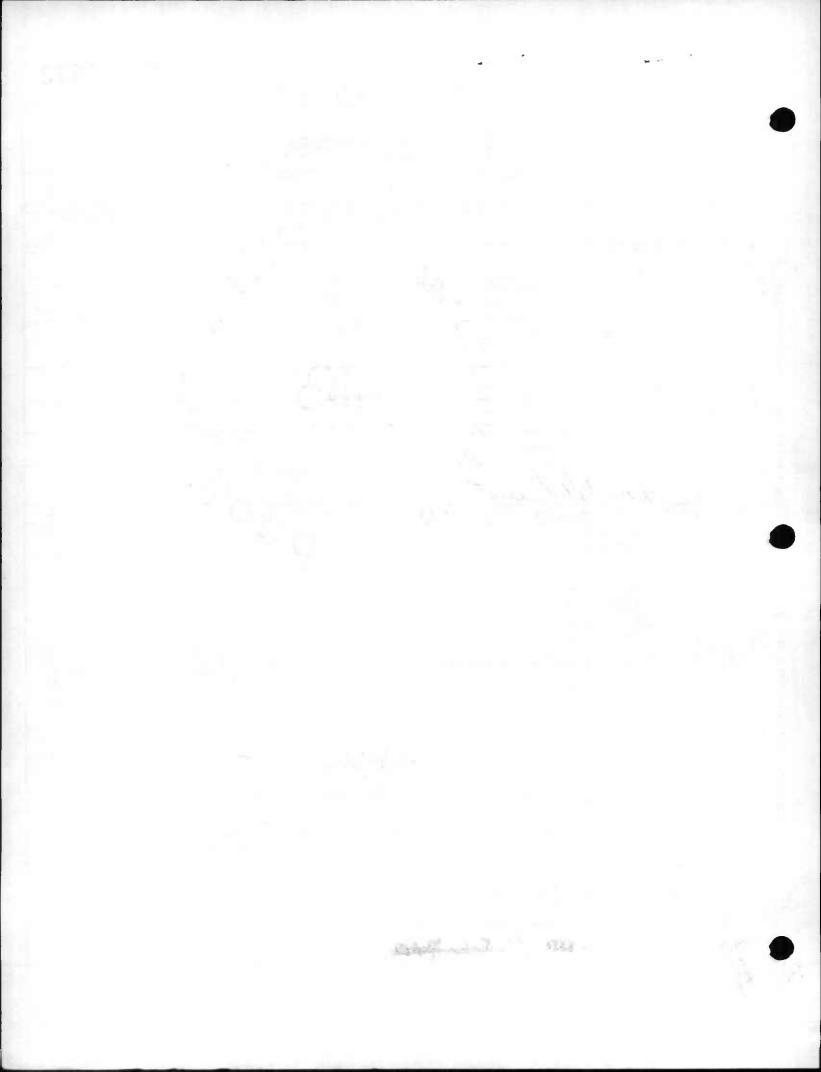
120 Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE cemetery, crematory or other place) 4 Donation 5 Other (Specify) Rehobeth PresbyterianCem. 3/13 Rehobeth, Maryland 21. SIGNATUBE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Melson Funeral HOme Mils PO BOX 64, Pocomoke City, Maryland21851 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory errest, Approximata shock, or heart failure. List pnly one cause on each line. IMMEDIATE CAUSE (Final Onset and Death disesse or condition DUE TO (OR AS A CONSEQUENCE OF): resulting in death) 60 Cour CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events QUE TO (OR AS A CONSEQUENCE OF)resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA ng Home 5 - Realdence 8 - Other (Specify) 4 🗆 Nu 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO В 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CHATIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE non 124924 D 3/4/93 2

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

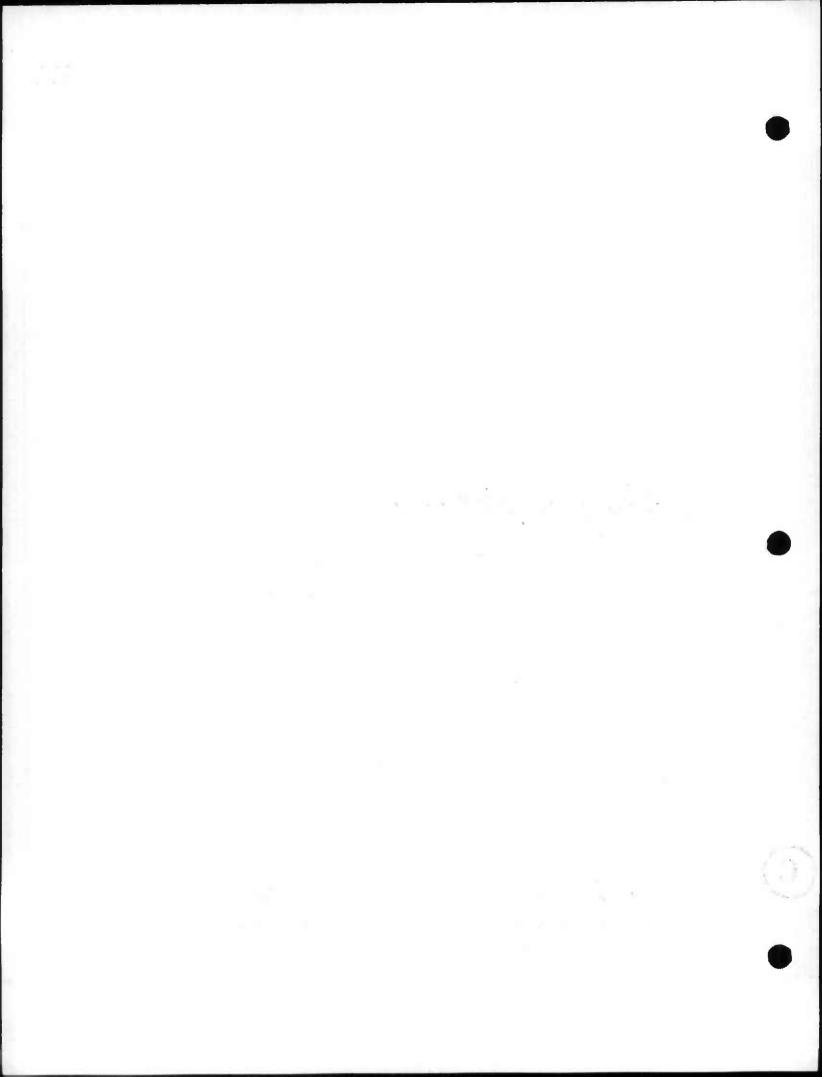
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL	HYGIEN	E	, (00/3	
	1. DECEDENT'S NAME (First, Middle, Last)		****			2. DATE O	F DEATH		3. 1	TIME OF DEATH	-
	GERTRUDE ELIZABI	ETH ARONHAL	T			монтн 3	5	1993	AR 8:	30 a M	
	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE Of	F BIRTH Day, Year)	0.1	BIRTHPLA	CE (State or Foreign	_
N		1 □ M 2 X F 80	YRS.	OHTHS DAYS	HOURS MIN.	Dec.	9 19	12	Mary	land	
	9a. FACILITY NAME (If not institution, give stre			b. CITY, TOWN (R LOCATION OF E	DEATH		9c. COUNTY	OF DEATH	1	
5	Teets Personal Ca	re Home		0aklan	d			Garr	ett		
E E	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CITY,	TOWN OR LOCAT	ION				104	I, INSIDE CITY	_
8	Maryland Ga	rrett		0ak1					1	LIMITS?	
اد	10e. STREET AND NUMBER				ZIP CODE			10g. CITIZEN			_
ER/	114 W. Pennington	Street			21550			USA			
FUNERAL DIRECTOR		12. WAS DECEDENT EVER IN			ENDENT OF HISPA				RACE - /	American Indian,	
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TYES			city Cuban, Maxic		can, etc.)		Black, Wh	ille, etc.	
									Specify:	hite	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION completed)	16a. DECEDENT'S U (Give kind of wo	rk done during ma	ON st of working	16b. F	IND OF BUS	INESS/INDUST	RY		
٦	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Secret			C+	nto C	overnm		(DND)	١
MO	17. FATHER'S NAME (First, Middle, Last)		Decree	ary	18. MOTHER'S N				ent	(DNK)	_
ŏ		onhalt			Pearle				on		
BE	19s. INFORMANT'S NAME (Type/Print)		196. MAILING A	DDRESS (Street a	nd Number or Rura						-
2	Mrs. Gladys Norde	ck		Bradle				Md. 21			
	20a. METHOD OF DISPOSITION		PLACE AND DATE OF	DISPOSITION (No		DATE	_	CATION — City		Stats	-
	1 Description 1 Description 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	rai from State	akland Ce	metery		3/8	Oak	land,	Mary	land	ì
	21. SIGNATURE OF THERAL SERVICE/LICE	NSEE		22. NAME AF	ID ADDRESS OF F	ACILITY					
	Kolunt Mcx	Quest	100167	Durst	Funeral	l Home		0. Box		21550	
	23. PART I. Enter the diseases, or co	emplications that caused	tha death. Do no	t enter tha mo	da of dying, su	ch se cerdie	c or respi	ratory arrest.	riu.	Approximata	+
	shock, or heart failure. LI IMMEDIATE CAUSE (Final	ist only ons cause on a	sch ilna.							Interval Between Onset and Death	
1		Ventricula	r Arrhyth	mia					j	Sudden	
	to sating in death)	DUE TO (OR AS A	CONSEQUENCE OF)							Judgell	-
Z	Sequentially list conditions, 6.	Arterioscl		rdio-Va	scular	Diseas	e			Unknown	
CERTIFICATION	if sny, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):								1
임	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):								
E	resulting in death) LAST								į		1
	d.								- +		
¥	PART II. Other significant conditions			the underlying	cause given in	n Part I. 2	PERFOR			RE AUTOPSY FINDINGS ILABLE PRIOR TO	1
ă	_Alzheimer's Dise	ase - Sever	al Years			.	T YES 2	₩ NO		PLETION OF CAUSE DEATH?	ı
ž									1 🗆	YES 2 NO	ı
Z Z											
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PL OTHER:	ACE OF DEATH (C	heck only one)					-
¥ I	YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Oulp 28s. DATE OF INJURY	etlent 3 DOA 4	-	e 5 ☐ Residence						4
	XX Natural 5 ☐ Pending	(Month, Day, Year)	INJUI	RY WO	RK?	260. DESC	HIBE HOW IF	JURY OCCURE	ED		ł
B	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJURY	— At home, ferm, str			28f, LOCAT	ION (Street a	nd Number or R	hural Brusta	Number	ł
	4 Homicide 6 Could not be determined	building, etc. (Spec	tfy)				Town, State)			Tentholog,	ŀ
וב	29e. CERTIFIER 1 CERTIFYINO PHYSICI	IAN: To the best of my knowl	edge death occurred	at the time date	and place, and du	a to the organ	(a) and man				1
COMPLETED		On the basis of exemination							use(s) end	manner as stated.	I
	296 SIGNATURE AND TITLE OF CERTIFIER	///	// /		29c. LICENSE NU			29d. DATE SIG			4
#	H. L. F N	h Zain	Mon !	LR							
임	JO. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE		rint)	D 0565	-		Marc	11 0,	1993	1
	Herbert H. Leight				. Oaklar	nd. Ma	rvlan	d 215	50		
	31. DATE FILED (Month, Day, Year)	32. BEGISTRAR'S SIGNA	ATURE		, Junial	ru, rid	- у тан	4 41)	J 0	-111	1
	MAR - 8 1993	galia Devidos	1- Porphille								
		-									4



CALL MAN AND AND AND AND AND AND AND AND AND A	TO THE CONTINUE PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE RANEPAL CIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Deor, of Health and Mental Myriène prior to burial companion or removal	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - FOR STATE OF MARYLAND / DEPART CERTIFI	MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIENE REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY	3. TIME OF OEATH
	Roosevelt Bush, Sr.		March 11, 19	993 11:00 A M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
	3/8-62-1906 X 88 YRS.		May 23, 1904	Georgia
000	9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF D	EATH 9c. C	COUNTY OF CEATH
6	Carriage Hill Nursing Home	Silver Spring	Mo	ontgomery
DIRECTOR		TOWN OR LOCATION		10d. INSIDE CITY
	D.C. N/A Wa	shington		LIMITS?
A L	10e. STREET AND NUMBER	10f. ZIP CODE	10g.	CITIZEN OF WHAT COUNTRY?
FUNERAL	1213 E Street N.E.	20002	Ur	nited States
1 5	11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 YES 2 NO	13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Yes or No-	- 14. RACE - American Indian, Black, White, elc.
B	3 💢 Widowed 4 Divorced IF YES, GIVE WAR OR DATES	If yes, specify Cuban, Mexica		Specify:
	15. DECEDENT'S EDUCATION 18e. DECEDENT'S U	SUAL OCCUPATION		Black
COMPLETED	(Specify only highest grade completed) (Give kind of wo	dk done during most of working	16b. KIND OF BUSINESS	INDUSTRY
글	Elementary/Secondary (0-12) College (1-4 or 5+) Supervi	cor	D C C	
	17. FATHER'S NAME (First, Middle, Lest)		D.C. Gove	
BE C	Dave Bush		Hector	-7
TO BE COM	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING A	DDRESS (Street and Number or Rural	Route Number, City or Town, State,	Zip Code)
	Albert Bush 3655 H	ighwood Drive S	.E., Washingt	on. D. C. 20020
18	209. METHOD OF DISPOSITION 1 \(\Oldot \) Burial 2 \(\oldot \) Cremation 3 \(\oldot \) Ramoval from State 20b. PLACE AND DATE OF Complex C	DISPOSITION (Name of	DATE 20c. LOCATION	Cify or Town, Stats
	4 Donation 5 Other (Specify) Maryland N	atl.Mem.Park 3/	15/93 Laure1	, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	McGuire Funer	CILITY	
	Harry F. Libber	17400 Georgia	Ave. N.W. Wa	shington, D.C.
	23. PART I. Enter the diseases, or complications that caused the daeth. Do no shock, or heart fellure. Liet only one cause on each line.	t enter the mode of dying, suc	h as cardiac or reapiratory	arrest, Approximata
	IMMEDIATE CAUSE (Final			Interval Between Onset and Death
	disease or condition	Droinoms		
	DUE-TO (OR AS A CONSEQUENCE OF):	, /	/	
NO.	Sequentially list conditions, b. Swinoma of	- prestate		
AT	If any, leading to immediate cause. Enter UNDERLYING			
CERTIFICATION	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):			
E	resulting in death) LAST			j i
	0.			
Ŋ.	PART II. Other eignificent conditions contributing to deeth but not resulting in	the underlying cause given in	Pert I. 24s. WAS AN AUTOPS PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC			1 TES 2 NO	COMPLETION OF CAUSE OF DEATH?
×			_	1 TYES 2 NO
AN	05 445 0455 05550000			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF OEATH (Che	eck only one)	
14S	1 Inpatient 2 ER/Outpatient 3 DOA 4	Nursing Home 5 - Residence	6 ☐ Other (Specify)	
	1 Netural 5 Pending (Month, Day, Year) INJUR	Y WORK?	28d. DESCRIBE HOW INJURY	OCCURED
βÁ	2 Accident Investigation 3 Suicide 6 Could not be 28s. PLACE OF INJURY — At home, tarm, str	7 M 1 YES 2 NO	None	
<u> </u>	4 Homicide determined building, etc. (Specify)	net, factory, ornes	28t. LOCATION (Street and Numi City or Town, State)	ber or Rural Route Number,
9	290. CERTIFIER X CEPTIEVING PHYSICIAN T. 13			
COMPLET	(Check only one) 2 MEDICAL EXAMINER: On the bast of examination and/or investigation,	at the lime, date and place, and due	to the cause(e) and manner as a	stated.
	29b, SIGNATURE AND TITLE OF CERTIFIER			
8	-0/ /1/ MO	29c. LICENSE NUN	7.C/ 29d. D	MATE SIGNED (Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, P.	WILL.	-7	5/1-/75
	Vohy B. Umhau. 8805/	mn. Ave., C.	heur Chose	Md-
	31. DATE FILED (Month, Day, Year) 32_REGISTRAR'S SIGNATURE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	
	MAR 16 '93 Sichie Tavidma Bondage			



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HIGH IN. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE HIGHAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should a fill the completely marked and the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

INFORMANT: If them 28 is marked, or flem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)				0.271111	2. DATE OF DEAT	Н	3. TIME OF DEATH	
	Joseph J	Berman	nn			March 1	3. 1993 YE	7:00 P. M	
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Yes	8.1	BIRTHPLACE (State or Foreign Country)	
	264-14-2035		32 yrs.	MONTHS DAYS	HOURS MIN.			w Jersey	
<u>«</u>	9e. FACILITY NAME (If not institution, give s			9b. CITY, TOWN (OR LOCATION OF D	DEATH	9c. COUNTY		
DIRECTOR	16700 Batchellors	Forest Road		01ney			Montgo	omery	
I H	10e. STATE 10b. COUNTY	1	10c. CITY	, TOWN OR LOCAT	TION			10d. INSIDE CITY	
		gomery		01ney				LIMITS?	
3AL	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?	
FUNERAL	16700 Batchellors Forest Road 20832 United Stat 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OR HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OR HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OR HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OR HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OR HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OR HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OR HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OR HISPANIC ORIGIN? (Specify Yee or No.— 14. RACE — American Status 15. WAS DECEMBENT OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANIC OR HISPANI								
	1 Never Merried 2 Merried	FORCES? 1 YES	2 NO	If yes, sp	ecify Cuben, Maxic	NIC ORIGIN? (Specifier, Puerto Ricen, atc.	Yee or No- 14.	RACE — American Indian, Black, White, etc.	
BY	3 ₩ Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 - YES	2 NO Speci	ify:		Specify: White	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16e. DECEDENT'S I	USUAL OCCUPATION done during mo	ON at of weeking	16b. KIND OF	BUSINESS/INDUST		
9	Elementery/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)	st or working				
M M	17. FATHER'S NAME (First, Middle, Lest)	5	SALESMA	N			LESALE M	EAT	
	SIGMUND BERMAN	ſ				AME (First, Middle, Me	iden Surname)		
BE	19e. INFORMANT'S NAME (Type/Print)		10h MAII INC	ADDRESS (Owner)	ELSIE	BAUM Route Number, City or			
5	TOBY ROSENTHAL							LE,MD. 20833	
	20e. METHOD OF DISPOSITION	20b	PLACE AND DATEO	F DISPOSITION (No	me of		LOCATION — City		
	1 ☐ Burlel 2 ☆ Cremetion 3 ☐ Reme 4 ☐ Donation 5 Ø Other (Specify)		etery, cremetory or oth	rt Crema	torv	1	exandria		
	21. SIGNATURE OF HUNERAL SERVICE LIC	ENSEE		22, NAME AN	D ADDRESS OF FA	CILITY			
	Dary 1	n. Bise		1170	isky-Goi Rockvill	aberg Mer	norial Cr	napels, Inc.	
	23. PART i. Enter the diseases, or o	complications that caused List only one cause on a	the death. Do no	ot entar tha mo	da of dying, suc	ch es cardiac or re	papiratory arrest,	Approximeta	
	IMMEDIATE CAUSE (Final							Intarval Between Onaet and Death	
	disease or condition resulting in death)	. Ca	rdiou	اماء	las -	Dise	a sa .		
		DUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION	Sequentially liet conditions,	DUE TO (OR AS A	CONSEQUENCE OF	t.					
CAT	if sny, leading to immediata cause. Enter UNDERLYING								
Ē	CAUSE (Disease or Injury that initiated evente	DUE TO (OR AS A	CONSEQUENCE DF)	:					
8	resulting in deeth) LAST	I							
AL C	PART II. Other significant conditions	s contributing to death b	uthot resulting in	tha underlying	I cause given in	Part i. 24a WAS	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS	
S	parking	was De	sees.		g	PER	FORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIC	Con	aone	- 01	' dee	Shorte	T T YES	S 2 NO	OF DEATH?	
ž			4	2				1 YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Ch	neck only one)			
YSI	1 M YES 2 □ NO	1 Inpatient 2 ER/Outp		OTHER: 4 Nursing Home	5 Residence	6 Other (Specify)			
	27. MANNER OF DEATH 1 Setural 5 Pending	(Month, Day, Year)	26b. TIME INJU	RY WOI	RK?	2ed. DESCRIBE HO	W INJURY OCCURE	D	
Β¥	2 Accident Investigation	26. DI ACE OF IN HIEW	10		ES 2 NO				
COMPLETED	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Speci	— Al nome, tarm, sti	reet, factory, office	'	26f. LOCATION (Str. City or Town, St	eet end Number or Ru ate)	ıral Route Number,	
9	29e. CERTIFIER								
MP	(Check only one) 2 MEDICAL EXAMINER	CIAN: To the best of my knowled: On the basis of examination	edge, death occurred	I at the time, date	end place, end due	to the ceuse(e) end	menner ea stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER			, in my opinion, de					
BE	2-6	Tara	50		29c. LICENSE NUI	WBER (NED (Month, Day, Year)	
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type. F	Print)			marc	h 14, 1993	
	John F. Tauber, M.				414. Ret	thesda M	D 20814		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	TURE		ידד, הכו	mesua, M	D 20014		
	MAR 16 '93	Julia Davidso	n Pandall						



BALTIMORE, MARYLAND 21215-0020	rSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	ate be executed within 24 hours after	ysician and completely filled in by the	prior to burial, cremation, or removal,	traumatic event, the medical e
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	The law requires that the death certific	te has been signed by the attending ph	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal,	em 23 shows any injury, or other
DIVISION OF VI	HOSENIAL OR ATTENDING PHYSICIAN:	PREHAL DIRECTOR: After this certifical	within 72 hours after death with the Sta	RPORTANT: If Item 28 Is marked, or its
U	THE		pe filed	IMPOR

	1 - FOR STATE REGISTRAR	;	STATE OF MARY		DEPARTME			MENTA	L HYGIEN	E		0070
- 1	1. DECEDENT'S NAME (First, MI								OF DEATH	NY .		TIME OF DEATH
			BERMAN					3			3	3:107"
2000	1.80CIAL SECURITY NUMBER	575	□ M 2 (VF	E (In yrs. last	YRS. MONTH		IF UNDER 24 HRS. HOURS MIN.	(Mon	OF BIRTH	03	Country)	ACE (State or Foreign
DIRECTOR	BESIDENCE OF DECE	Home	of Gr	Was	1 -		VILLE			MONT		
ည္က		Ob. COUNTY			10c. CITY, TOWN	OR LU-AI		-			10	Dd. INSIDE CITY
- 1	MARYLAND 100. STREET AND NUMBER	MONTGO	MERY		GAITH	-	RG ZIP CODE			100 CITIZE		LIMITS? X YES 2 NO NT COUNTRY?
FUNERAL	894 BAYRIDGE	E DR.					20878					TATES
5	11. MARITAL STATUS	L STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No. 14, RACE — American Control of the Con						- American Indian,				
BY	1 Never Married 2 Married PORCES? 1 YES 2X NO If yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White,						WHITE					
COMPLETED	15. DECEDI (Specify only hi	ENT'S EDUCATI ighest grade com	ON pleted)	(Giv	EDENT'S USUAL w kind of work don	e durina mo		180	. KIND OF BUS	SINESS/INDUS	STRY	
וי	Elementary/Secondary (0-12)	e) c	ollege (1-4 or 5+)	100	Do NOT use retired MAKER	.)		1	OWN HO	ME		
8	17. FATHER'S NAME (First, Middl	lle, Last)		поги	S PIMKER		18. MOTHER'S NA					
	BARNETT LEV	/Y					ETHEL R				S	
BE	19a. INFORMANT'S NAME (Type	/Print)		19b.	MAILING ADDRE	SS (Street a	nd Number or Rural					
임	EDWARD BERMA	AN .		894	BAYRII	GE D	R. GAIT	HERS	BURG,	MD 20	0878	
	20a. METHOD OF DISPOSITION 1 X Buriel 2 Cremation	3 - Removal			ND DATE OF DISP		me of	DAT	E 20c. LO	CATION - CI	ly or Town	, State
	4 Congion 5 Other (Sp 21. SIGNATURE DE FUNDRAL S			CEDA	R PARK	CEMET		3/1	0 PAR	AMUS,	NJ.	
	* A 11/1	111	n au		1)ANZA	NSKY-GOL	DBER				
	23. PART I. Enter the dise	ases, or com	pications that caus	ed the dea	th. Do not ent	er the mo	ROCKVILL da of dylng, suc	h as car	diac of reapi	ratory arres	it,	Approximate
	IMMEDIATE CAUSE (Finel		ohly one cause on	each line.	0 -	Δ						Interval Between Onset and Death
	disease or condition resulting in death)	a	Severe	Why	hume	, De	menter					
			DUE TO (OR AS	A CONSEQU	UENCE OF):							
<u> </u>	Sequentially list condition		DUE TO (OR AS	A CONSEQU	JENCE OF):							
S	if any, leading to immedia cause. Enter UNDERLYING	a										
Ė	CAUSE (Disease or Injury that Initiated events		DUE TO (OR AS	A CONSEOU	JENCE OF):							
CERTIFICATION	resulting in death) LAST	d										
A C	PART II. Other significant	conditions co	ontributing to death	but not re	sulting in the	underlying	ceuse given in	Part I.	24s. WAS AN		24b. W	ERE AUTOPSY FINDINGS
									PERFOR		C	MILABLE PRIOR TO OMPLETION DF CAUSE
MEDIC										23	100	F DEATH?
5	25. WAS CASE REFERRED TO M EXAMINER?		OSPITAL:		ОТН	_	ACE OF DEATH (Ch	eck only o	ne)			
PHYSICIAN:	1 YES 2 NO	10	Inpatient 2 ER/O		DOA 4 DA	ursing Hom	5 Residence					
	1 Netural 5 Per		(Month, Day, Year	5	28b. TIME OF INJURY		RK?	28d, DE	SCRIBE HOW II	NJURY OCCU	RED	
B	2 Cividado	estigation	M 1 VES 2 NO 288. PLACE OF INJURY — At home, farm, street, factory, office 281. LOCATION (Street and Number or Rural Route Number,						te Number.			
	_ 0 _ 000	uid not be ermined	building, etc. (S)	oecify)					or Town, State)			
ן ב	29e. CERTIFIER (Check only	YING PHYSICIAN	: To the best of my kno	owledge, dear	th occurred at the	time, date	and place, and due	to the ca	use(a) and man	ner sa stated		
COMPLET			n the besis of axamina									nd manner as stated.
ш	295 STONATURE AND TITLE OF	FCENTIFIER					29c. LICENSE NUI	MBER		29d. DATE	HIGNED (M	onth, Day, Year)
0	(lluin).	Mad	arano M.	2			1391	66		▶3	8/9	3
	ALVIN S.	MADA	MANG, N	10 6	27) (Type, Print) 12/ M	NTK	USE RE	R	OCKVIL	18 M	2	20852
	31. DATE FILED (Month, Day, Yes	9 3	32. REGISTRAR'S SIG	SNATURE	andell.					20/1		

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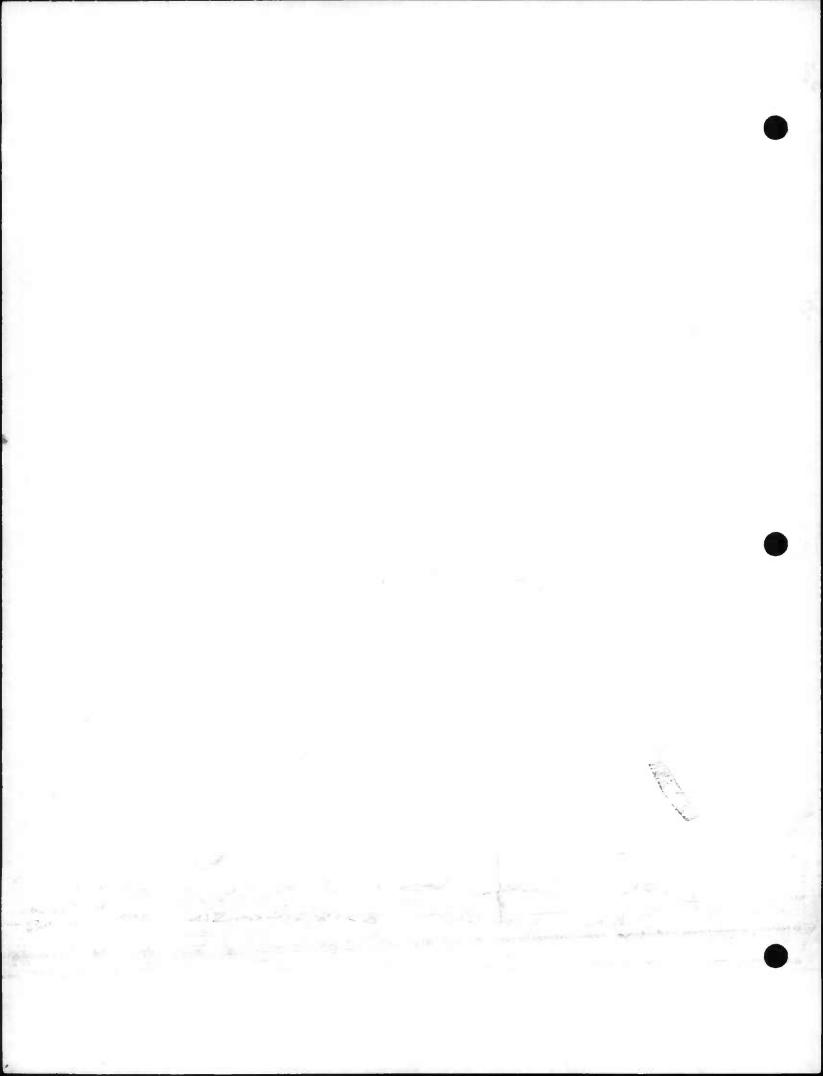
IMPORTANT: If Item

use as the burial-transit permit. Pages 1, 2, 3 hours after death. Page 6 may be retained by the hospital or attending physician. Por detached director, page 5 should be the funeral гетома TO THE FLURERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by Included. Arithin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remo within executed 2 that the death certificate The law PHYSICIAN: THE MOSPITAL OR ATTENDING

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Henry John Bender YEAR 3 93 2.04 4. SOCIAL SECURITY NUMBER 5. SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 X M 2 | F 73 134 05 9318 1 - 23 - 20NEW YORK 9e. FACILITY NAME (If not institution, give etreet end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington Adventist Hospital Takoma Park Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Prince Georges Hyattsville 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 7103 Pony Trail Lane 20782 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 1 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 — YES 2 [3] NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Merried BY SpechWhite 3 Widowed 4 Divorced IIWW COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) ENGINEER DEPT OF DEFENSE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) JOHN BENTKOWSKI notified at CATHERINE PIROT BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 GEORGIA BENDER SAME AS 10 e 99 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1 Burial 2 Cremation 3 Ren
4 Donation 5 Other (Specify) FT. LINCOLN CEMETERY 3/17/93 BRENTWOOD, MD 21. SIGNATURE OF FUNERAL SERVICENLICENSEE examiner 22. NAME AND ADDRESS OF FACILITY 254 Carol TAKOMA FUNGTA HOME ler D.C. 2001 nu WAShing Ton medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Finel Onset and Death** disease or condition the Cardio Oarsanlar resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24s. WAS AN AUTOPSY PERFORMED? any 1 TYES 2 NO Shows OF DEATH? 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Item HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 4 Nursing Home Residence 6 Other (Specify) 6 27. MANNEH OF BEATH 28a. DATE OF INJURY (Month, Day, Year) 286. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED Is marked, 1 Matural 5 Pending Investigation M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 28 4 Homicide 29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. (Check only one)

CERTIFYING PHESICIAN: 10 the best of my anomeoge, occurred at the time, dete and place, and due to the cause(s) and manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day Year) BE 29c. LICENSE NUMBER 945,800 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BOTFUSO 8218 WS CONSIN ber bh 31. DATE FILED AND 32. MEGISTRARIE SIGNATURE

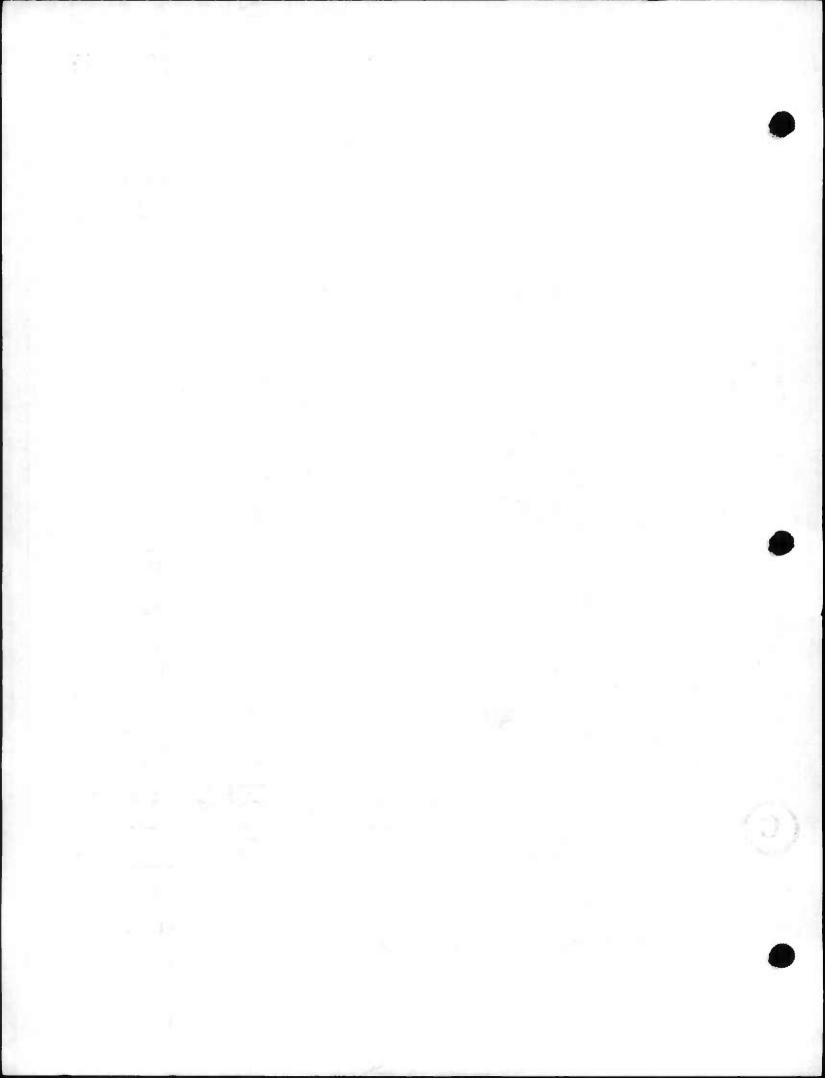
GIANA DAVIDAMA PROPRINTE



ON OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPING ANTENIANG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hosp	TO THE FUNCTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and the first of the following the first of	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - REGISTRAR CERTIFICATE OF DEATH REG. NO.												
	1. DECEDENT'S NAME (First, Middle, Last)			OF DEATH			3. TIME OF DEATH						
	Rosemary D. Beach						Marc	h 14,		YEAR	12:30 P. M		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday) II	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE (OF BIRTH		8. BIRTH	PLACE (State or Foreign		
	579-64-1939	1 □ M 2 🕁 F	91	YRS.	ONTHS DAYS	HOURS MIN.		6 · 1	201	Country Irel			
	9e. FACILITY NAME (If not institution, give st	Λ.	91	9	b. CITY, TOWN (R LOCATION OF DE		0, 1	9c. COUNT				
5	11415 Commonwealth Dr. Apt.#103 Rockville							Montgomery					
10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 1									10d. INSIDE CITY				
									- 1	LIMITS? 1 YES 2 NO			
- 11	10e. STREET AND NUMBER								10g. CITIZ	EN OF W	HAT COUNTRY?		
FUNEHAL	11415 Commonwealt	415 Commonwealth Dr. Apt.#103 20850							U.S.A	Δ.			
Š	11. MARITAL STATUS	12 WAS DECEDEN	T EVED IN II S	ADMED	13. WAS DEC	ENDENT OF HISPAN				14. RACE	— American Indian,		
	1 Never Married 2 Merried	FORCES? 1	YES 2	Хио		2 NO Specify		Rican, etc.)		Specif	, White, atc.		
0	3 Widowed 4 Divorced	J				_ ,,			j		White		
COMPLEIED	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	16a.	DECEDENT'S US			16b.	KINO OF BUS	SINESS/INDU	JSTRY			
4	Elementery/Secondary (0-12)	College (1-4 or 5+	,	life. Do NOT use i	etired.)								
	12		Но	me Make	r		C	wn Ho	ne				
ַלָּ	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, A	Aiddle, Maiden	Surname)				
	Isaac Dugan					Rose Tee	er						
	19e. INFORMANT'S NAME (Type/Print)			19b. MAILINO A	DDRESS (Street a	nd Number or Rural	Route Numb	ber, City or Tow	n, State, Zip (Code)			
-	Thomas A. Beach.	Jr.		13420	Glen Le	a Way, R	ockv	ille,	MD 20	850			
	20a. METHOD OF DISPOSITION 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	and team State	20b. PL/	ACE ANO DATE O	FOISPOSITION	(Name	OATI	E 20c. LO	CATION — C	aty or To	wn, State		
	4 Donatton 5 Other (Specify)	Wall from State				netery	3/1	7 Sil	ver Si	prin	g, MD		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. NAME A	D ADDRESS OF FA	CILITY						
	186	1	-			L Funeral				. 1	- MD 20077		
	23. PART I. Enter the diseases, or o	complications the	t caused the	death Do not							g, MD 20877		
	ahock, or heert fellure.					do or dying, odd		2100 O. 100p	ioloty office	,	interval Between		
	IMMEDIATE CAUSE (Fine)										Onset and Death		
	resulting in deeth)			nfarcti	.on						Immediate		
5	Sequentielly list conditions,	Athero		SIS ISEOUENCE OF):							25 years		
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING		(0								İ		
2	CAUSE (Disease or injury that initiated events	c. DUE TO	(OR AS A CON	SEOUENCE OF):							+		
=	resulting in deeth) LAST	-											
3		d									<u> </u>		
4	PART if. Other significant condition	e contributing to	deeth but n	ot resulting in	the underlyin	g cause given in	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
							_	1 TYES	Z NO		COMPLETION DF CAUSE OF DEATH?		
							_		**		1 YES 2 NO		
PHYSICIAN: MEDIC										100			
Ž	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					LACE OF DEATH (C/	neck only or	10)					
2	1 X YES 2 NO	HOSPITAL:	ER/Outpatien		OTHER:	ne 5 🎇 Residence	8 🗆 Othe	r (Specify)			1.00		
	27. MANNER OF DEATH	28a. OATE OF (Month, E	INJURY	26b, TIME INJUI	OF 28c. IN	JURY AT	28d, DE	SCRIBE HOW	INJURY OCC	URED			
M 1 YES 2 NO													
25a, PLACE OF INJURY — At home, farm, street, factory office 28t, LOCATIO							ATION (Street or Town, State	ON (Street end Number or Rural Route Number,					
4 Homicide determined													
MPLE	290. CERTIFIER 1 X CERTIFYING PHYS	ICIAN: To the best of	my knowledou	e, death occurred	at the time, dat	and place, and du	to the car	use(e) end ma	nner as state	ed.			
Ė	(Check only one) 2 MEDICAL EXAMINE										e) end manner ee stated.		
3			,										
Z L	296. SIGNATURE AND TITLE OF CERTIFIE	11000	da	m. A		29c. LICENSE NU					(Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED COM	DE DE DEST	//\ \ \	Man .	D23127			Ma	irch	16, 1993		
-	The state of the s						_						
	Kevin G. Nealon,					25 Chevy	Chas	se, MD	2081	5			
	31. DATE FILED (MOTTI), Day, (Ser) 93	32. HEGISTR	AR'S SIGNATUR	Rendel	2								



THE HOSPITAL ORATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 meurs after death. Page 6 may be retained by the hospital or attending physician.

THE PUNEDAL, PRECIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If tem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

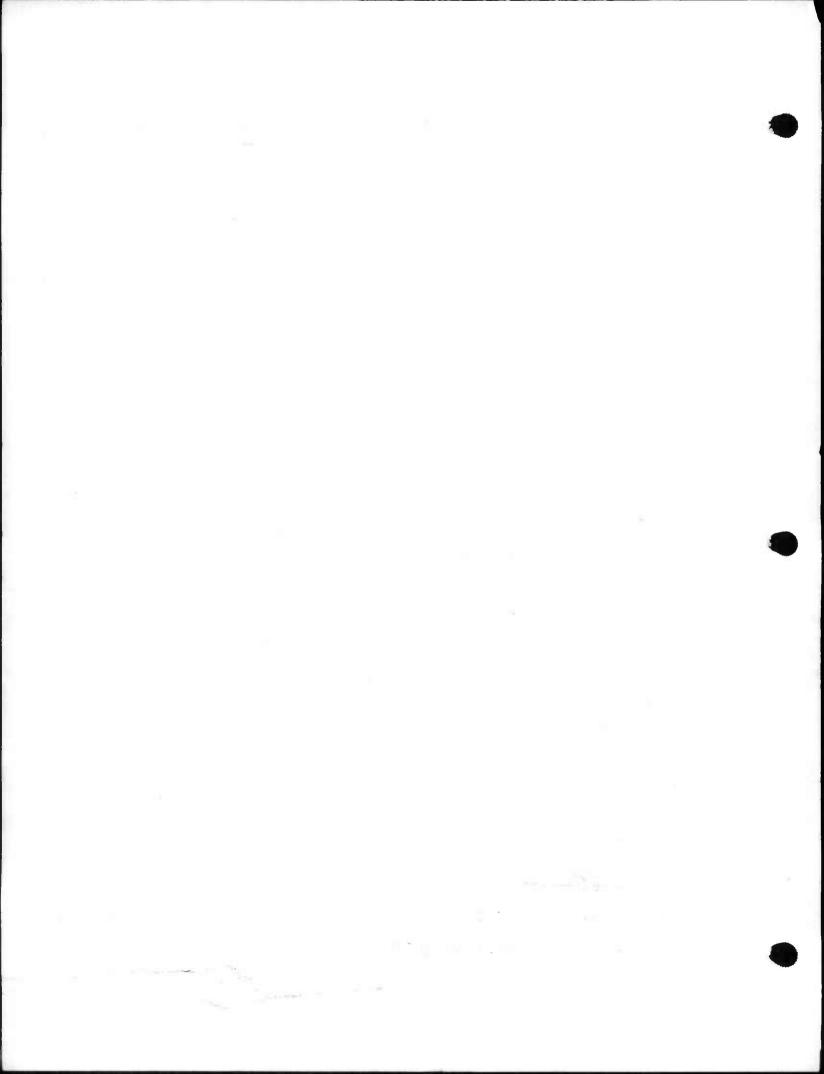
31. DATE FILED (Merrith, Day, Year)

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	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.											
,	Matilda B. Brown	S 20 Am										
i	O 1 7 4 C E 2 O 7 V Y O MONTHE DAYS HOURS MAN (Month, Day, Year) Country)	(Month, Dey, rear) Country)										
OR	Greater Laurel-Beltsville Hosp. Scity, Town or Location of Death Prince Ge											
DIRECTOR	Marriand Howard Columbia	NSIDE CITY LIMITS? YES 2 NO										
FUNERAL	100. STREET AND NUMBER 8706 Airybrink Lane 101. ZIP CODE 21045 U.S.A.	10g. CITIZEN OF WHAT COUNTRY? Ü.S.A.										
ΒY		or No 14. RACE — American Indian, Black, White, etc. Specify:Black										
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4 or 5+) 4 School Teacher 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Public Schools											
BE CON	17. FATHER'S NAME (First, Middle, Lest) Owen Sykes 18. MOTHER'S NAME (First, Middle, Melden Symmeme) Hattie Baker Sykes											
TO B	198. INFORMANT'S NAME (Type/Print) Lillian B. Joyner 190. MAILING ADDRESS (Street and Number or Rural Route, Number City or Town, State, Zip Code) 5612 Thunderhill Rd., Columbia, MD 21045											
	20s. METHOD OF DISPOSITION 1 Burlai 2 Cremation 3 Removal from State 4 Donalton 5 Other (Specify)											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 4906 IVerson Place House of Diggs, Temple Hills, MD											
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abook, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Cardwar Maddur Faulure Approximate interval Between Onset and Death											
z	DUE TO (OR AS A CONSEQUENCE OF): SCASS Securdary 6											
ICATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	that initiated events resulting in death) LAST d. Winay truet infection											
MEDICAL	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Virgular Lateral Complete Lateral Compl											
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:											
	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF (NJURY AT WORK?) 28d. DEŞCRIBE HOW INJURY OCCURED WORK?											
тер ву	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide datarmined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route N City or Town, State)	lumber,										
COMPLET	29a. CERTIFIER (Check only One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.	manner an stated.										
BE	296. SIGNATURE AND TITLE OF THER 29d. DATE SIGNED (Month)), Day, Year)										
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

4 8 00 32. REDISTRARS GIGNATURE
SINGLE DEMOSION PONDERS



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מלה הוני והלה בלה	urs after death. Page 6 may be retained by the hosp	In by the funeral director, page 5 should be detached removal	edical examiner must be notified at once.	
	TO THE HOSPITAL AND THE MESTIVE AND SOCIAL THE IBW requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE PLINERAL DATE OF A TIME certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to find willing a many and the state Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
(TO THE HOSPITAL OF APPENDINGS	TO THE FLINEPAL DIVINOR AND THE FIRST PARTY AND THE PROPERTY OF THE PROPERTY O	IMPORTANT: If Item 28 is man	

											9:	3 (08680)
	1 - FOR STATE REGISTRAR	STATE OF N	MARYLAND / CE				DEAT			YGIENE				
	1. DECEDENT'S NAME (First, Middle, Lest)								2. DATE OF D	DEATH			3. TIME OF DEAT	гн
		DeWitt	Clair E	Baldw	vin				March	ı 16,	199	3 YEAR	11:19	Рм
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest	t birthday)	IF UNDER		IF UNDER		7. DATE OF B			PLACE (State or Fo	oreign	
	377-38-4376	1 M 2 F	94	YRS.	MONTHS	DAYS	HOURS	MIN.	April 12,		1898 New		w Jersey	/
	9e. FACILITY NAME (If not institution, give street end number)				9b. CITY	r, TOWN C	OR LOCATIO	ON OF DE			NTY OF DE			
OR	Suburban Hospita		Bethesda						Mor	ntgom	nery			
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	T 10c, CIT	CITY, TOWN OR LOCATION								10d. INSIDE CITY	,		
SIR	Maryland Monto	gomery			Rockville								LIMITS?	
	10e. STREET AND NUMBER	Julier		1100	> K A T 7		ZIP COOL	E			10a, CITI	IZEN OF W	HAT COUNTRY?	NO
ER/	511 Meadow Hall	Drive				1			20851				States	
FUNERAL	11. MARITAL STATUS	12. WAS DECEOEN	IT EVER IN U.S. ARI	N U.S. ARMED 13. WAS DECENDENT OF HISP			OF HISPAN	PANIC ORIGIN? (Specify Yes or No- 14. F				- American India	en,	
	1 Never Married 2 Merried	FORCES? 1	XXYES 2 NO If yes, specify Cuban, Mexic					ın, Mexica	xican, Puerto Rican, etc.) Black					
Э ВУ	3 Widowed 4 Divorced		WW I										ite	
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade		16a. DE6 (Gi	16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)					16b. KIND OF BUSINESS/INDUSTRY					
Y.E	Elementary/Secondary (0-12)	College (1-4 or 5 -	+)	Clergyman					D-34 star					
NE NE	17. FATHER'S NAME (First, Middle, Last)	0	LOTE	этуун	ları		40 44077	TOTAL ALA		ligio				
		aldwin			18. MOTHER'S NAME (First, Middle, Me.						the second contract to			
H	19a, INFORMANT'S NAME (Type/Print)	1TUWIII	198	MAJLING	ADORES	a teent?) 2	Number	T'TE	Sophi:	a Co	COOK wn, State, Zip Code)			
2	DeWitt C. Baldwir	ı dr.							Drive,				60610	
	20s. METHOD OF DISPOSITION 20b. PLACE AND DAT							IOT	OATE OATE			City or Ton		
	1 Burial 2 A Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	cemetery, crer SUDU								lver Spring, Maryland			land
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY									Luita				
	Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910													
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate													
	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final CACACACACACACACACACACACACACACACACACACA													
	disease or condition ARVIAC ARREST													
	DUE TO (OR AS A CONSEQUENCE OF):													
N	DUE TO (OR AS A CONSEQUENCE OF): ATHEROSCLEROTIC CARDIOVASCWAR DISEASE Sequentially list conditions,													
CERTIFICATION	If any, leading to immediate													
길	CAUSE. (Disease or injury CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF):													
Ē	that Initiated events resulting in death) LAST													
핑	d													
AL	PART II. Other aignificant condition	s contributing to	death but not re	esuiting	in the ur	nderlying	couse g	given in	Part i. 24a	. WAS AN A		24b.	WERE AUTOPSY FI	
음	CARCINOMA OF THE PROSTATE, GASTRO- ENTERITS, DETYDRATION 220, NO 1 YES 2 () NO 1 YES 2 () NO													
ME	ENTERITIS, DETYDRATION 1 1 YES 2 NO													
ä														
PHYSICIAN: MEDICAL	EXAMINER?													
ΥS	1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)													
ᆸ	1 XNetural 5 Pending	Pay, Ybar)				28d. DESCRIBE HOW INJURY OCCUR			CURED					
B	2 Accident Investigation 3 Suicide & Could not be	F INJURY At ho	me farm	street fac			_ 							
	4 Homicide 8 Could not be	etc. (Specify)	JURY — At home, farm, street, factory, office (Specify)					281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
	29e. CERTIFIER 1 ACERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated.													
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and manner as stated.													
	296. SIGNATURE AND THE OF CONTRICE									piaca, and				unou.
H	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)													

Mizus,

Irving

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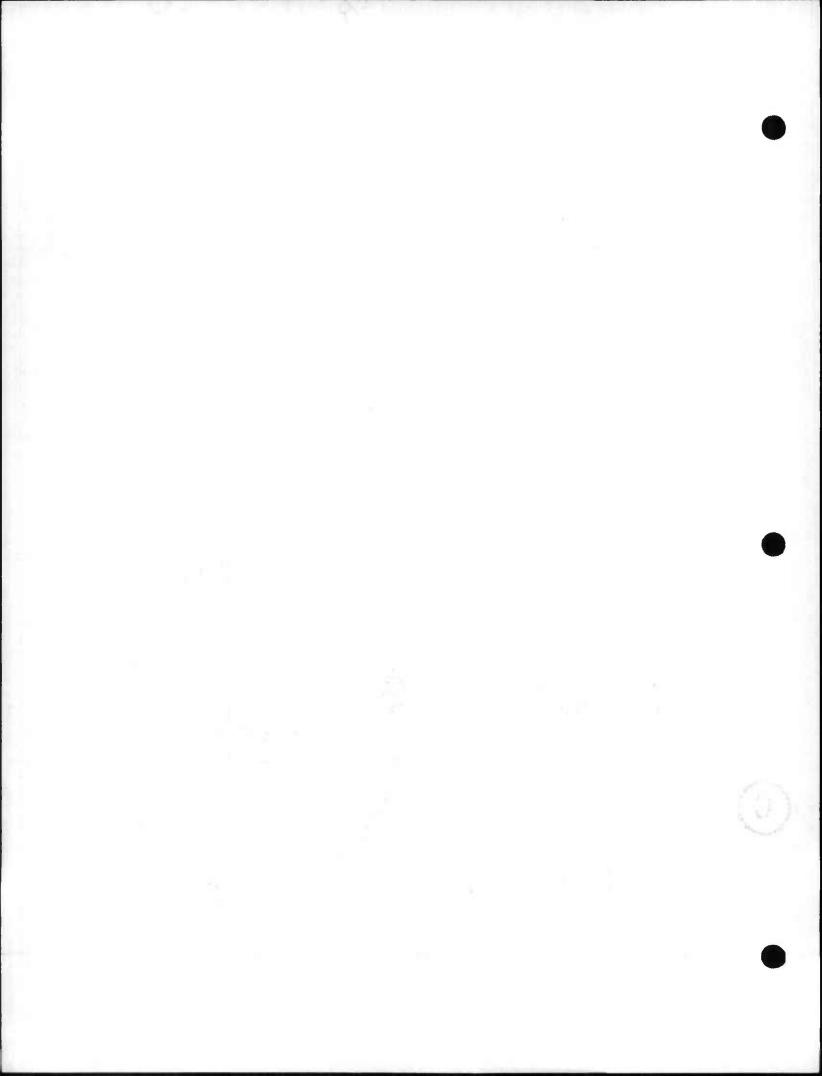
March 18.

D., 5413 Cedar Lane.

5413 Cedar Lane, #206-C, Bethesda, MD 20814

31. DATE FILEO (Month, Day, Year)
MAR 19 93 32. REGISTRAR'S SIGNATURE
Juna Davidson Rondell

DHMH-16 Rev 1/89



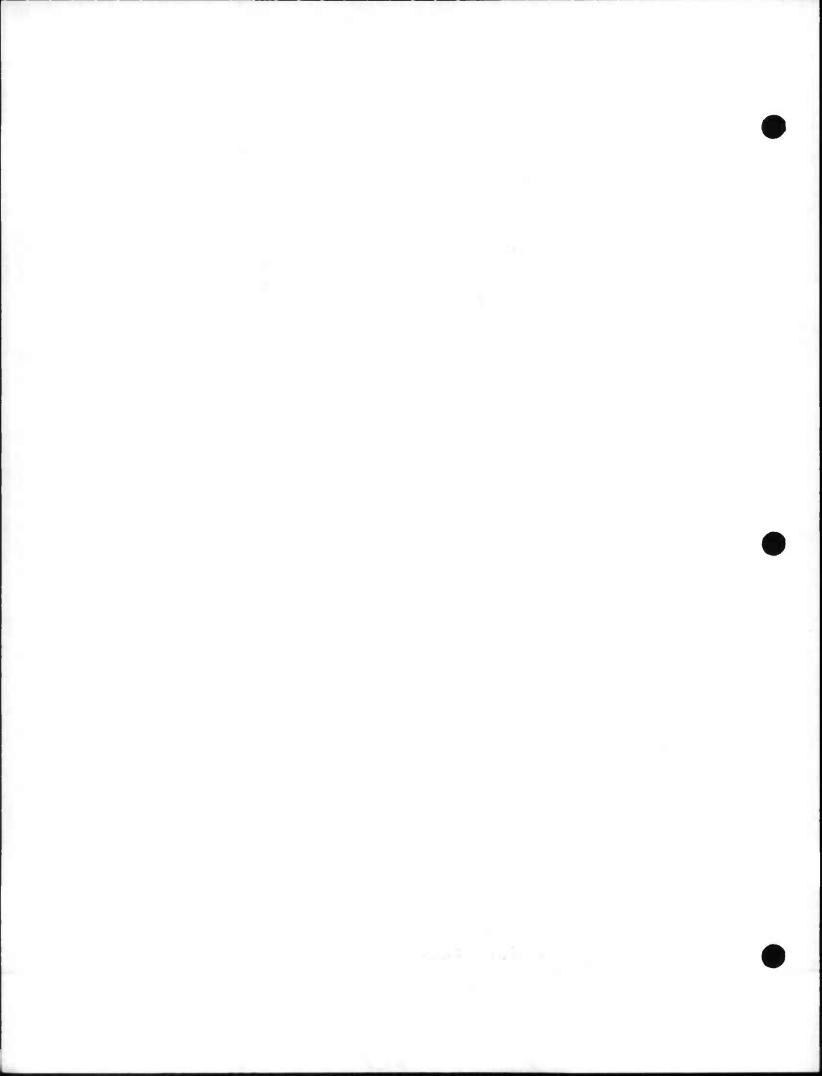
TO THE HISPITUL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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STATE	0F	MARYLAND	/ DEPARTMENT	0F	HEALTH	AND	MENTAL	HYG	IENE
			PEDTIEICATE		E DEAT			-	

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFICA			MENTA	L HYGIEN	E		
Ì	1. DECEDENT'S NAME (First, Middle, Last)		Butl	er		2. DATE	OF DEATH DA	4 199	EAR	TIME OF DEATH
	4. SOCIAL SECURITY SUMBER 217-32-4925	5. SEX 6. AGE (7 O YRS. MON	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH	8	BIRTHPLA	CE (State or Foreign ryland
O.B.	9a. FACILITY NAME (If not institution, give Southern MA	7 . []]	ospital "		TON	EATH		PRINC		DeoRger
DIRECTOR	Maryland Prin	nce George'	S 10c. CITY, TO	WN OR LOCAT		20		11111		1. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER				ZIP CODE		0		OF WHAT	YES 2 NO
FUNERAL	3204 Oak St.	12. WAS DECEDENT EVER IN FORCES? 1 YES			ENDENT OF HISPA		N? (Specify Yes			American Indian,
B	3 X Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2X NO Specify: Specify: Black									
COMPLETED	15. DECEDENT'S EDU (Specify only highest grad) Flegnantary/Secondary (0-12) 12th grade	College (1-4 or 5 +)	(Give kind of work of the Do NOT use ret) Clerk	done durina mo	N st of working		ederal			ent
	17. FATHER'S NAME (First, Middle, Last) Martin Procto	r	02021		16. MOTHER'S NA	ME (First,		Surname)	- L 11111	lenc
TO BE	19a. INFORMANT'S NAME (Type/Print) Mr. D. Jerry B	utler (Son)	196. MAILING ADD 365 En	ness (Street a	nd Number or Rural Oak C	Route Num	ber, City or Town	, Statu, Zio Co	md.	20601
1	20a. METHOD OF DISPOSITION 1 ② Burlel 2 Cremation 3 Ran 4 Donation 5 Other (Specify)	20b	. PLACE AND DATE OF DI	SPOSITION (Na	me of	DAT	E 20c. LO	ATION — City	or Town.	
	21. SIGNATURE OF FUNERAL SURVICE U			22. NAME AT	110S F	üner	al Ho	me,	[nc.	
	23. PART i. Enter the diseases, or	complications that caused	the death. Do not e							D.C.20
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Myecava	dial In	Fare	1					Interval Between Onset and Death
N	Sequentially list conditions,	· ATTEOSCLEN		do vo	sculor	- 0	150AS	e		3,45
RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	c	CONSEQUENCE OF:							
CERTI	that initiated events resulting in death) LAST	d	- CONSEQUENCE OF).							
¥	PART II. Other significant condition	ns contributing to death b	ut not resulting in th	e underlying	cause given in	Part I.	24a. WAS AN PERFOR	MED?	COL	RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE
MEDIC							, ,			DEATH? TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	от	HER:	ACE OF DEATH (Ch					
Ë	27. MANNER OF DEATH	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF			_	SCRIBE HOW III	LJURY OCCUR	ED	
<u> </u>	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 Y	ES 2 NO					
ETED	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spec	= Al Home, tarm, street	, factory, office		City	CATION (Street a or Town, State)	nd Number or I	tural Houte	Number,
COMPLE		ER: On the best of my knowless.							Juse(a) an	d manner as stated,
4	29b. SIGNATURE AND TITLE OF CERTIFIE	Fuldon	mo		29c. LICENSE NUI	MBER 27		29d. DATE SI	GNED (Mo	oth, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CAUSE OF DE	,		10 -	7 4 1		5,	rea	1790
	31 DATE FILED (Month, Day, Year) MAR () Q 1003	32. REGISTRAR'S SIGN	ATURE	e. 1	D. 0	206	كسا			
1	MAR U 9 1993	rela Sevidon Bo	md . 00							

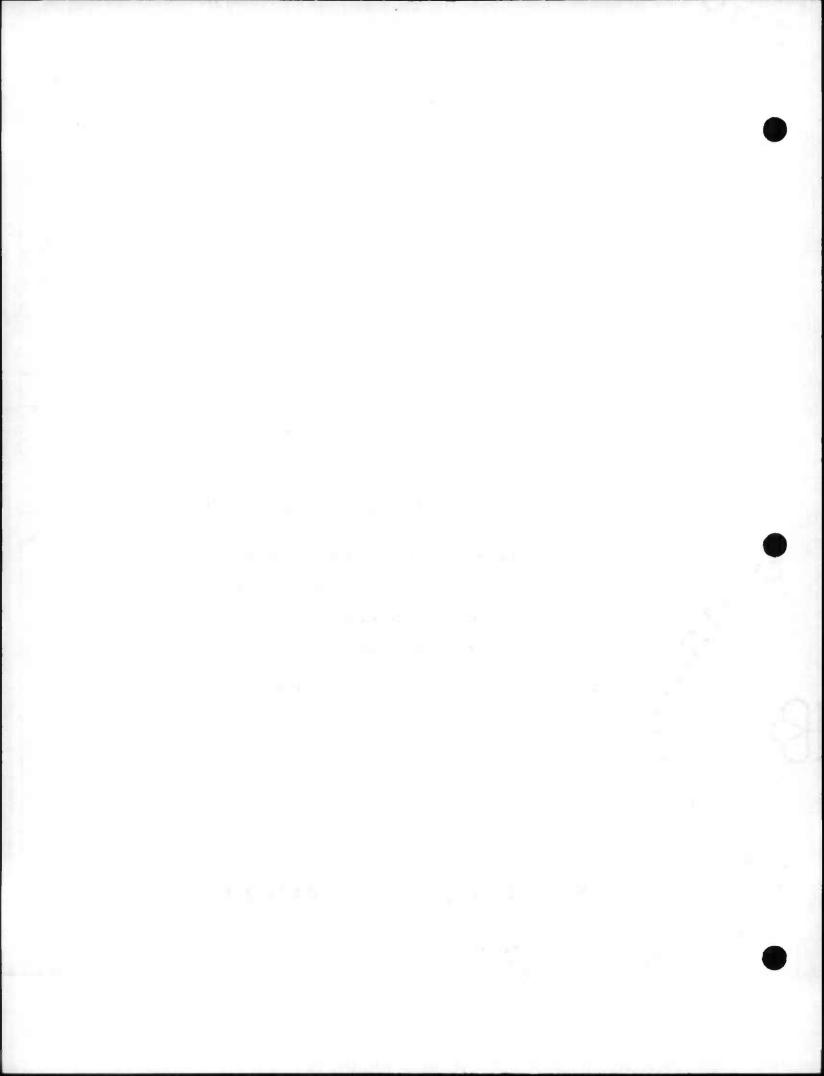


should

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	USPITAL UR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	NREAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3	thin 72 hours, after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	INT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
1	TO THE HOSPI	TO THE FUNER	be filed within	IMPORTANT:

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	EALTH AND M	IENTAL HYGIEN		00002
19	1. DECEDENT'S NAME (First, Middle, I	DOROTHY	BROIDY			2. DATE OF DEATH MONTH 3	1 93	3. TIME OF DEATH 1:55P
	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	THPLACE (State or Foreign
	238-58-7206 9a. FACILITY NAME (If not institution,	7	JZ YRS.	b. CITY, TOWN C	HOURS MIN.	(Month, Day, Year) 5 -29-40	NOI 9c. COUNTY OF	RTHCAROLINA
TOR	PRINCE GEORG	GE'S HOSPITAL (CENTER	CHE	VERLY			GEORGE
DIRECTO	MARYLAND PR	LINCE GEORGE'S		OWN OR LOCAT				10d, INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	106. STREET AND NUMBER 6300 CARRIN	GTON COURT	-	101	20745		10g. CITIZEN OF	WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES	2 NO	If yes, sp	ENDENT OF HISPANIC Cuban, Mexican, 2 NO Specify:	C ORIGIN? (Specify Yes, Puerto Rican, etc.)	Bla	CE — American Indian, ck, Whita, atc. scity:
LETED	15. DECEDENT'S (Specify only highest : Elementary/Secondary (0-12) 12th	EDUCATION grade completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of work life. Do NOT use in	done during mo	st of working	16b. KIND OF BUS		DLACK
COMPL	17. FATHER'S NAME (First, Middle, Las	0	Cher	HELPER		E (First, Middle, Maiden	VT.	
BEC	HAYWARD CL	•		_	LOUVI	ENIA EDMON	DS	
2	19a. INFORMANT'S NAME (Type/Print) FREIDA WIL	LIAMS				oute Number, City or Town		0746
	20a_METHOD OF DISPOSITION 1 (ABurial 2 Cremation 3 C 4 Donation 5 Other (Specify)		PLACEAND DATE OF I			1	NDOVER,	Town, State MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	Markon			VER RD. LA		MD 20795
KIIFICATION	immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A SEPTEMBER)		THE	,	mess S	YNDRIN	Interval Between Onset and Death
MEDICAL CE		ut noch	out not resulting in t	ha underlying	ceuse given in P	DEDECAR	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PL THER:	ACE OF DEATH (Chec	k only one)		
PHYSICIAN	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	1 Inpetient 2 ER/Outp 28s. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJ WO	URY AT RK?	Other (Specify) 28d. DESCRIBE HOW II	JURY OCCURED	
ED BY	2 Accident investigat 3 Suicide 8 Could no 4 Homicide detarmine	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, stre			28f. LOCATION (Street a City or Town, State)	nd Number or Rural	Route Number,
COMPLEIED		HYSICIAN: To the best of my know						(e) and menner as stated,
ם סו	296. BIGHATURE AND TITLE OF CERT	her			29c. LICENSE NUME	7 7	29d, DATE SIGNE	(Month, Day, Year)
-	30. NAME AND ADDRESS OF PERSON	I WHO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pri	nt)				
	31. DATE FILED (Month, Day, Year) MAR 0. 8. 100	32. REGISTRAR'S SIGN						



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	on arthurstonic principles. The last state of th
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		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC			MENTAI	L HYGIEN		
)	V V	1. DECEDENT'S NAME (First, Middle, Last)	~ Bo	hbi		 -	2. DATE MONTH	OF DEATH	ar - 9 .	S TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	/	F UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTH n, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
PI		240-68-8932	1042 F 4	/ YRS.	ONTHS DAYS	HOURS MIN.	Aug.	27,		North Carolina
2, 3 should	TOR	.99. FACILITY NAME (If not institution five str	- Adve-12	st Ass.	Tak	or location of d	rk,	MI	9c. COUNTY	yarf.
Pages 1,	DIRECTOR	104. STATE 10b. COUNTY	6	10c. CITY, 1	TOWN OR LOCAT	TION	de			10d. INSIDE CITY LIMITS?
physician. burlal-transit permit. Pages 1,	FUNERAL D	104. STREET AND NUMBER	: 11um	Rd.	101	J. ZIP CODE	793	?		1 X YES 2 NO
physician. burlal-trans	UNE	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	V.S. ARMED		ENDENT OF HISPA			USA or No- 14	. RACE — American Indian,
	BY	1 Never Married 2 🔀 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2 X NO ATES		ecity Cuben, Mexico 2 X NO Specia		Rican, etc.)		Specify: Black
use use	ETED	15, DECEDENT'S EDUC (Specify only highest grade of		16a. DECEDENT'S US (Give kind of work life. Do NOT use n	k done during mo		16b.	KIND OF BU	SINESS/INDUS	TRY
₹ £	PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Constru		Jorkor				
retained by the hospital 5 should be detached for notified at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		Constitu	CCIOH W	18. MOTHER'S NA	ME (First, A	Viddle, Meiden	Sumame)	
5 a 6	BE C	James Covington				Edna 1				
5 should notified	0	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural				
		Diane Covington 20a. METHOD OF DISPOSITION	20h	PLACE AND DATE OF		Rd., #202	2, Hy			MD 20783
9 25 2		1 Surial 2 Cremation 3 Remo		Harmony or other			/11/9		andove	-1
death. Page tuneral dire i.		21. SIGNATURE OF FUNERAL SERVICE LICE	HEEE //			D ADDRESS OF FA				
		1/////	fiften	642	389	ier's Fi Rhode Is	aland	Ave.	N.W.	
hours after ded in by the or removal.		23. PART i. Enter the diseases, or conshock, or heert feilure. L	implications that caused lat only one cause on e	the death, Do not ach line,	enter the mo	de of dyling, suc	h as card	llac Dr resp	retory arres	Approximate interval Between
fille on.		IMMEDIATE CAUSE (Finel disease or condition resulting in death)	PU MONO DUE TO (OR AS A	aly ec	tema					Onset and Death
B 2 - 2			DUE TO (OR AS A	CONSEQUENCE OF):						
and and	NO	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):						
ysiciar prior trau	CAT	cause. Enter UNDERLYING CAUSE (Disease or injury								
leath certificate be attending physician mal Hygiene prior to y, or other traur	CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
he death certificate the attending physical Mental Hygiene principary, or other th	CEH	d								
of the	Α̈́	PART ii. Other algorificant conditions diabetes m	contributing to death b	ut not resulting in	the underlying	g cause given in	Part i.	24a, WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
5 5 E E	MEDIC	hupertension					- 1	1 TYES 2	M NO	COMPLETION OF CAUSE OF DEATH?
been sign t. of Healt	Σ	hout free	N _				-			1 TYES 2 NO
The law ate best.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26, PL	ACE OF DEATH (C)	eck only on	e)		
ictan: The sertificate h the State [or item	YSIC	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 FR/Outp		THER:	e 5 🗆 Residence	8 🗆 Other	r (Specify)		
NG PHYSICIAN: The free this certificate sath with the State marked, or item		27, MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME C	Y WO	RK?	28d. DES	CRIBE HOW I	NJURY OCCUR	ED
	ВУ	2 Accident Investigation 3 Suicide B Could not be	28e. PLACE OF INJURY	- Al home, ferm, stre		YES 2 NO	28f. LOC	ATION (Street)	and Number or	Rurel Route Number.
E 8 8	MPLETED	4 Homicide 6 Could not be	building, etc. (Spec	ify)				or Town, State)		The state of the s
Se Con Part	PE	29a. CERTIFIER (Check only	IAN: To the best of my knowl	ledge, death occurred a	at the time, date	end place, and due	to the cau	se(e) end mar	ner as stated.	
THE FUNERAL THE FUNERAL SHE WITH 72 PORTANT: II	COM									ause(s) and manner as stated.
THE FLINES THE FLINES TIRED WITHIN PORTANT	BE	294 999 ATRINE AND TITLE OF CERTIFIER	a Datic	· Carl	20111	29c. LICENSE NU	MBER		29d. DATE S	IGNED (Month, Day, Year)
PP	0	30. NAME AND ADDRESS OF PERSON WHO PATHOLIC CZapp, MI	COMPLETED CAUSE OF DE	ATH (ITEM 27) Care Co	m	0441	61		3	14/93
3	1					451 Blac	denst	ng Ro	, colm	as Manor, MD 20722
		31. DATE FILE MAR 1 7 1993	32. REGISTRAR'S NON	ATURE Pandal	2					

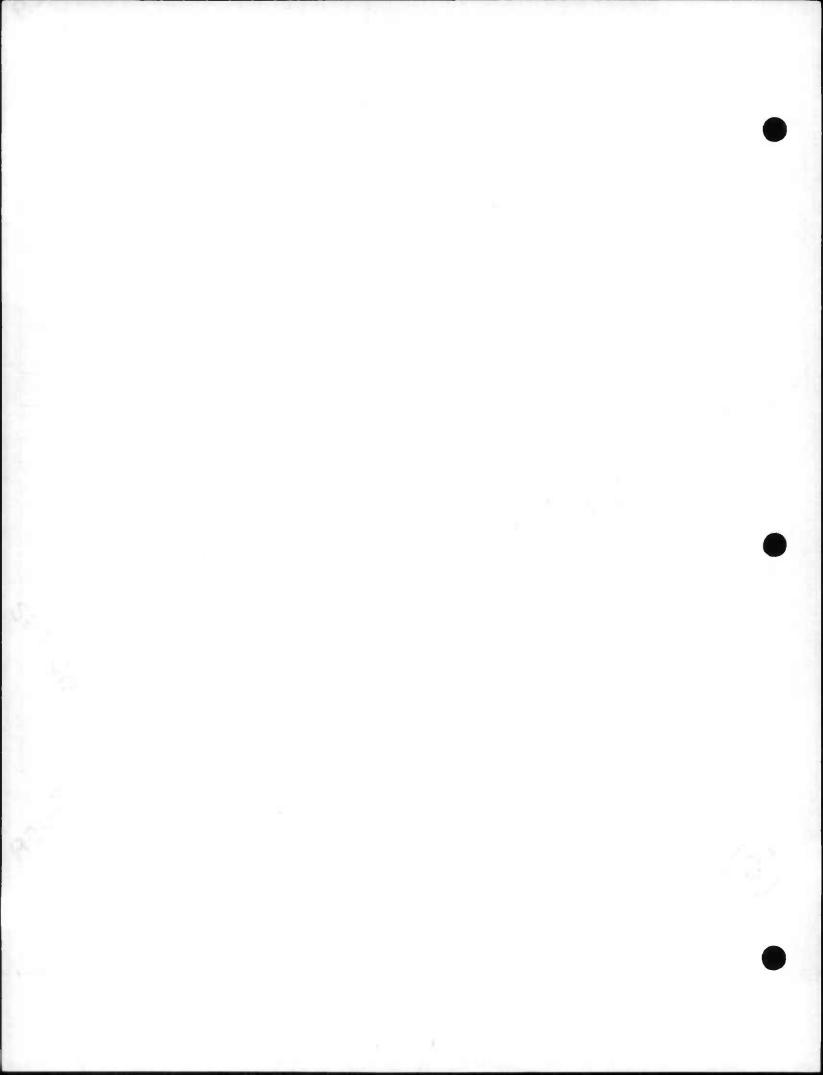
DIVISION OF VITAL R

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

NO DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Illiem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AN	
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.
CEDENT'S NAME (First, Middle, Last)		2 DATE OF DEATH

	1 - STATE REGISTRAR	SIAIE UF MAH			OF DEAT		MENTAL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)		<u> </u>	IOAIL	OI DEA	-	2. DATE OF DEATN		3	. TIME OF DEATH
	SHIRLEY Lee	BLACKBU	PN				3/10/93	WAY	YEAR	1.32 PM M
			GE (In yrs. last birthday)	IF UNDER 1	EAR IF UNDER	24 HRS.	7. DATE OF BIRTH		8. BIRTNPL	ACE (State or Foreign
1	219-34-6538	□ M 2 💢 F	56 YRS.	MONTHS C	MYS HOURS	MIN.	(Month, Day, Year) 05/24/19	36	Country)	e, Maryland
1 1	9a. FACILITY NAME (If not institution, give stree	t and number)		9b. CITY, T	OWN OR LOCATI	ON OF DE			NTY OF DEA	
O.	PRINCE GEORGES HOS	P.CTR.		CHEVE	RLY			PRIN	ICE GE	ORGE
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY									
E		C1-	200	Y, TOWN OR						Dd. INSIDE CITY LIMITS?
	Maryland Prince	George's	Be	erwyn	Heigh					X YES 2 NO
RA	100000000000000000000000000000000000000					-		1		AT COUNTRY?
FUNERAL	6106 Ruatan Stree	2. WAS DECEDENT EV	ED IN II C AGMED	T 40 NM	207		IIC ORIGIN? (Specify Ye		S.A.	
	1 Never Married 2 Married	FORCES? 1 1	ES 2 NO	If y	es, specify Cubs	n, Mexica	n, Puerto Rican, etc.)	s or No—		- American Indian, White, etc.
BY	3 Widowed 4 Divorced	Tries, onve went	IN DATES	''	YES 2 NO	Speciny	<i>r</i> :		Specify:	White
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor		16a. DECEDENT'S	USUAL OCC	UPATION ing most of working		16b. KIND OF BU	SINESS/IND	DUSTRY	
		College (1-4 or 5+)	life. Do NOT u	se retired.)	ing most or working	N.				- 4
MP	12		Chie	f Opei	rator		U.S.	Capit	ol	
8	17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, Maiden			
R	Virgil L. Raines						Ravenso			
2	19a. INFORMANT'S NAME (Type/Print)		(Route Number, City or Tox			
	Cheri L. Catanese					et, l	Berwyn He			
	20s METHOD OF DISPOSITION 1AV Suriel 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	I from State	206. PLACE AND DATE CAMPLE OF CO. CO. CO. CO. CO. CO. CO. CO. CO. CO.	of DISPOSITI	ON (Name of	02/			City or Town	
1 3	21. SIGNATURE OF FLINERAL SERVICE LICEN	SEE	Fillos Cel		ME AND ADDRE			sterr	iport,	Maryland
	1	D M.	,	Fr	ancis (Casc	h's Sons F	uner	al Ho	me, P.A.
	Jack a) True	nd	47	39 Bal 1	timor	re Avenue	, Hy	attsvi	lle, MD
	23. PART. Enter the diseesea, or com ahock, or heart failure. Lis	nplications that cau t only one cause o	used the deeth. Do o on each line.	not enter th	e mode of dy	ing, suci	h as cardiec or resp	iratory an	reat,	Approximate Interval Between
1 1	IMPEDIATE CAUSE (Final	0	tio 11	lack						Onset and Death
	resulting in death)	0 0								1 dey
			AS A CONSEQUENCE O	F):						1 101
No	Sequentially list conditions, b.		AS A CONSEQUENCE O	Pi:						1 de
\¥	if any, leading to immediate cause. Enter UNDERLYING			•						
E	CAUSE (Disease or injury that initiated events	DUE TO (OR	AS A CONSEQUENCE O	F):						
CERTIFICATION	resulting in death) LAST									
	PART II. Other significent conditions of	ontdbutten to don	the house man association in	l= ab d						
CAL		~1hocy to			chron		Part I. 24s. WAS AN PERFO		A	ERE AUTOPSY FINDINGS MILABLE PRIOR TO
	Aludandura.	Pinlmone		,	CAYO		1 YES :	1 DAG		OMPLETION OF CAUSE F DEATH?
Σ	cle solanesta	- 1 C	1-11-12-12-12-12-12-12-12-12-12-12-12-12	- sec			_		- 1	☐ YES 2 ☐ NO
AN	25. WAS CASE REFERRED TO MEDICAL	7 70-	TYPETOPIC	חוזיי						
PHYSICIAN:	EXAMINER?	OSBITAL:		OTHER:	26. PLACE OF D					
₹	1 VES 2 NO 1	28a, DATE OF INJU			g Home 5 Re	sidence	8 Other (Specify) 28d. DESCRIBE HOW	N #150 00	011050	
	1 Natural 5 Pending	(Month, Day, Ye		JURY	WORK?	NO	286. DESCRIBE HOW	INJURY OC	COMED	
ВУ	2 Accident Investigation 3 Suicide a Could not be	28s. PLACE OF INJ	URY — At home, farm,			,	28f. LOCATION (Street	and Number	or Burnt Bou	te Number
	4 Homicide 8 Could not be	building, etc. (Specify)				City or Town, State)	G TWIST TOO	101100,
l iii	29a, CERTIFIER 1 CERTIFYING PHYSICIA	N: To the heat of my li			4		Van Vandere	- Junio		
COMPLET	(Check only one) 2 MEDICAL EXAMINER: (to the cause(a) and ma			nd manner as stated
8	29b. SIGNATURE AND TITLE OF CERTIFIER									
8	On In (In	1 1	14 tendiny	Physic	29c. LICI	2070	79	29d. DAT	E SIGNED (M	fonth, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO C							1	70/13	
	30. NAME AND ADDRESS OF PERSON WHO C				cerbel.	t Ro	L. #(3)	rechi	ook 1	20706
	31. DATE FILEMAR 1 2 1993	32. REGISTBAR'S.	aurdson-Rand	ell.						



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

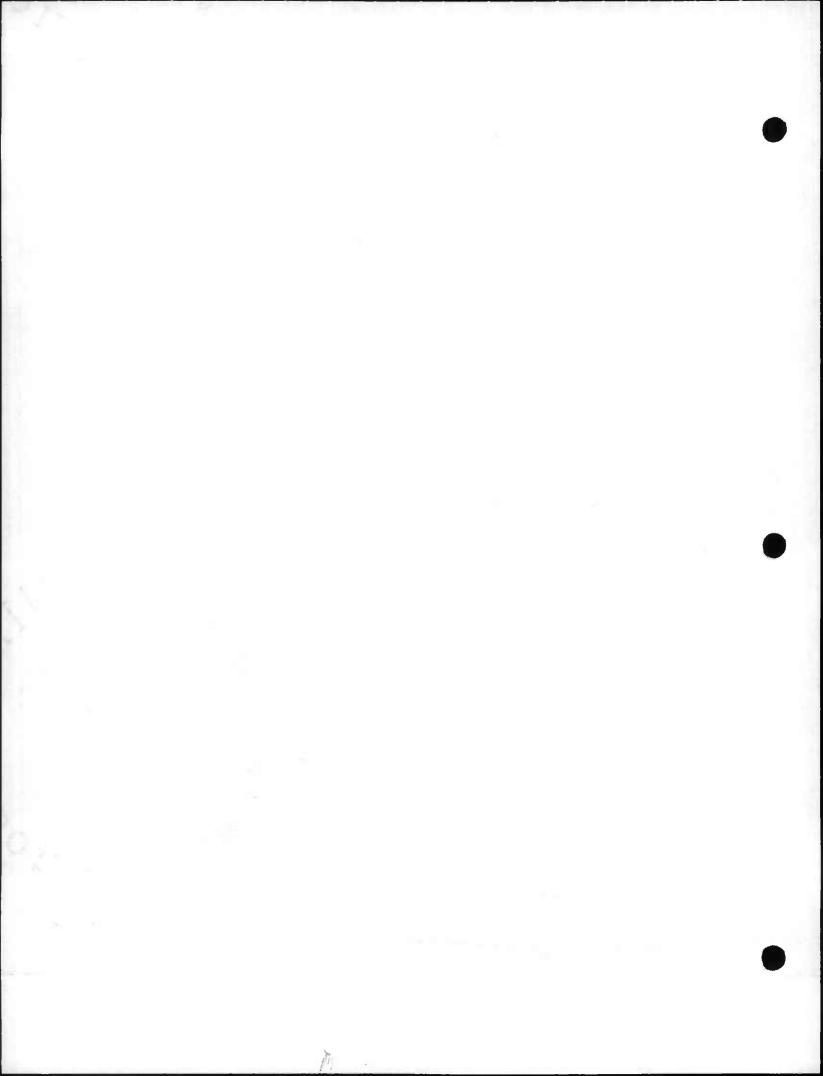
THE HOSETAL OF ATTENDIG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE MUREAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the timeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should life within 22476Urs after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

	REGISTRAR		CEI	KIII	ICATE (IF DEA	111		REG. NO.			
1	1. DECEDENT'S NAME (First, Middle, Last) ALBERT B	ORDERS						2. DATE OF MONTH	DEATH &	W .	95 S	3. TIME OF DEATH Some M
	4. SOCIAL SECURITY NUMBER 700-05-8703	CXXM 2 F	AGE (In yrs. last b	oirthday) YRS.	IF UNDER 1 YE MONTHS DA		MIN.	7. DATE OF (Month, D	lay, Year)		Country	PLACE (State or Foreign y)
NO.	sa. FACILITY NAME (If not institution, give: 5719 67th Ave.	street and number)			Ph. CITY, TO	N OR LOCATI	ON OF DE				NTY OF DE	
151	RESIDENCE OF DECEDENT											
DIRECTOR	-	v ce George'	s		r, town on L erdale	CATION						10d. INSIDE CITY LIMITS? XX YES 2 NO
FUNERAL	5719 67th Ave.					20737	E					hat country? States
B≺	11. MARITAL STATUS 1 Never Married 2 Married XX Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 I	YES 2 NO	ED	If yes	DECENDENT (, specify Cube YES 2 NO	in, Mexica	n, Puerto Rice	Specify Yes in, etc.)	or No	14. RACE Black Specif	- American Indian, White, atc.
COMPLETED	15. DECEDENT'S EDL (Specify only highest grade Elementary/Secondary (0-12)	CATION o completed) College (1-4 or 5+)	16a. DECE (Give life. D	EDENT'S kind of w	USUAL OCCUI work done during a retired.)	ATION most of working	ng		hern			Rail Road
MPI		2	Ste	no (Clerk							
BE CO	Albert J. Borders Mary Hardin											
5	190. INFORMANT'S NAME (Type/Print) Christopher Arn	ey	19b. (MAILING 719	67th	et and Number	or Runal F iver	dale,	City or Town	n, State, Zip 20737	Code)	
	20e. METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 3/8/93 Brentwood, Maryland											
-	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc.											
	22 DART I Francisco de	1 Confe			340	Blad	ensb	urg Ro	l. Br	entwo	ood,	Md. 20722
	23. PART I. Enter the diseases, or shock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition	List only one ceuse	on each ilne.						or reapi	ratory arr	rest,	Approximate interval Between Onset and Death
	resulting in death)	a. CONGE DUE TO (OF	R AS A CONSEOU			1 +1	1700	TE				YEARS
ATION	Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING	b DUE TO (OF	R AS A CONSEQU	ENCE OF	7):							
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	OUE TO (OF	AS A CONSEOU	ENCE OF	י):	<u> </u>						
EDICAL	PART II. Other significent condition	ns contributing to de	eth but not res	iuiting i	n the under	ying ceuse (given in		PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Σ								-				1 YES 2 NO
A	OF MAC CACE DEFENCES TO LIVE TO											
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 P NO	HOSPITAL:			OTHER:	L PLACE OF D						
448	27. MANNER OF OEATH	1 Inpatient 2 El		DOA 28b. TIM		INJURY AT	sidence	8 Other (S		HIEV OO	CHIPED	
	1 Natural 5 Pending	(Month, Day,			URY	WORK?	_ NO	20u. 023CH	IDE NOW II	SUNT OC	LUNED	
тер ву	2 Accident investigation 3 Suicide 8 Could not be determined determined determined billding, etc. (Specify) 28e. PLACE OF INJURY — Al home, farm, street, factory, office City or Town, Stete) 28e. PLACE OF INJURY — Al home, farm, street, factory, office City or Town, Stete)											
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS											
	- 0											
TO BE	Tolonghe line	40				29c. LICI	22	780		29d. DAT	3/7	(Month, Day, Year)
F	30. NAME AND LOORESS OF PERSON WHE	R AO COMPLETED CAUSE AO PARTIE PROPERTY AND THE PARTIE PROPERTY PROPERTY AND THE PARTIE PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPERTY PROPER	F DEATH (ITEM :	Yee	Print)	· CN	Dr.	Or.	een 5	eft	Me	120770
	31. DATE FILED (Month, Day, Year)	JA. REMISTRAR'S	SIGNATURE	2						. , ,		



DHMH-16 Rev 1/89

REG NO

er death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

FOR

STATE REGISTRAR

C RECORDS DIVISION OF VITAL

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-	I ATTENDING PHYSICIAN: Th
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH BRIDBANNAR BRANDON 12 4. SOCIAL SECURITY NUMBER 5. SEX B. AGE (In yrs. lest birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign 1 W M 2 | F N/A 24 2 Maryland use as the burial-transit permit, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR University of Maryland Med. Ctr. Baltimore Baltimore City RESIDENCE OF DECEDENT 10a. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Laure1 XXXVES 2 NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 9338 Palmer Place 20708 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES XX NO Specify: 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No FORCES? 1 YES XXNO
IF YES, GIVE WAR OR DATES 1XXNever Married 2 Married Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade ò Elementary/Secondary (0-12) College (1-4 or 5+) detached N/A N/A N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) page 5 should be notified at Christopher S Bredbenner BE Deborah A. Trainum 19e. INFORMANT'S NAME (Type/Print) eed and Number or Rurel Aquie Number City or Towa State, Zip Code)
P.L. Laurel, Md. 20708 2 Deborah A. Bredbenner 9 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must DATE director, p Lincoln Cemetery 3/10/93 Brentwood, Maryland Fort 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY the funeral Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd. Brentwood, Lincoln Funeral Home, Inc. 20722 Bladensburg Rd. Brentwood, Maryland 13% removal medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory erreat, à Approximate shock, or heart feilure. List only one cause on each line. .5 Interval Between 6 filled IMMEDIATE CAUSE (Final **Onset and Death** and completely fille burial, cremation, traumatic event, the disease or condition_ Multisystem resulting in death) day DUE TO (OR AS A CONSEQUENCE OF) NECROTIZING CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 if any, leading to immediate cause. Enter UNDERLYING prior CAUSE (Disease or Injury the attending phy or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 23 shows any Injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS and AMAILABLE PRIOR TO signed Health a COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO been t, of PHYSICIAN: has be Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: certificate h OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 9 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, this (1 Natural 1 YES 2 NO After t BY 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28I. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be BE COMPLETED DIRECTOR: hours after 28 4 Homicide 29a, CERTIFIER 1 🗹 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 祖記 MPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner es stated. 29d. DATE SIGNED (Month, Day, Year)

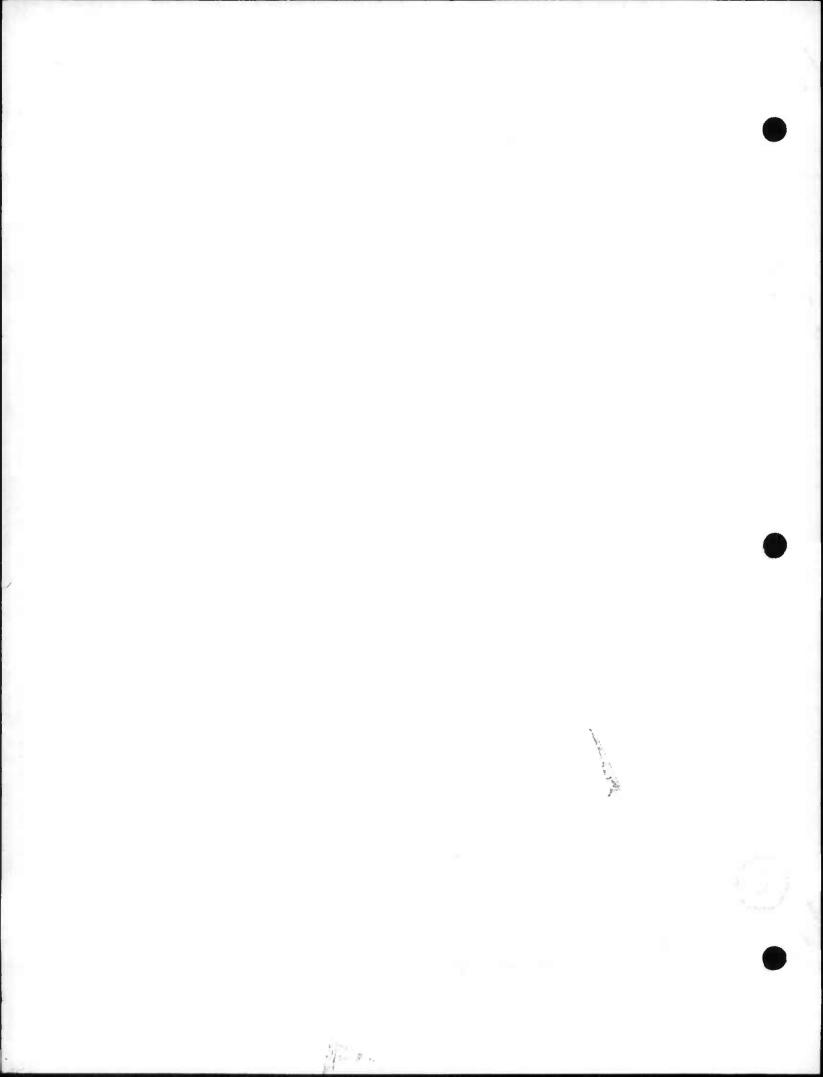
3 /7/93 G56485 Keeger F a 2 WHO COMPLETED CAUSE OF DEATH ITEM 27) (Type, Greene 22

32. REGISTRAR'S SIGNATURE

1993

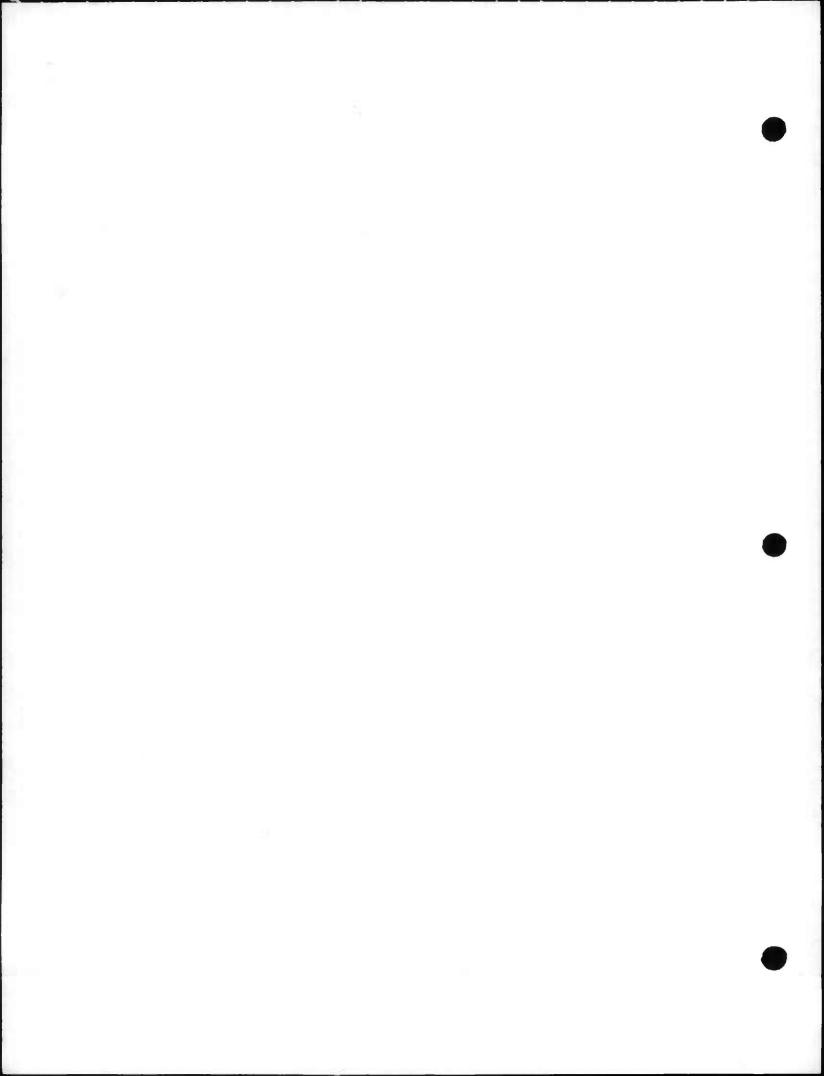
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



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68760,
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P.O.
RECORDS,
F VITAL
DIVISION

		FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTME			MENTA	L HYGIENE REG. NO.				
	- 8	1. DECEDENT'S NAME (First, Middle, Last,					2. DATE	OF DEATH		EAR 3.	TIME OF DEATH	_
		James Warren					Fet		199		2:55 A	М
PI	Ņ.	4. SOCIAL SECURITY NUMBER 219-20-4211	1)(1 M 2 C F 71	YRS. MONTH		IF UNDER 24 HRS. HOURS MIN.	fMont -	OF BIRTH h. Day. Year) -14-21	M	BIRTHPLA Country) WLYLO	CE (State or Foreig INC	7
2, 3 should	стоя	98. FACILITY NAME (If not institution, give Frederick Memo. RESIDENCE OF DECEDENT	· ·		reder	UCK	EATH		sc. COUNTY	deric		
t. Pages 1,	DIREC	10e. STATE 10b. COUNT	derick	10c. CITY, YOW Fred	n on Local			•			1. INSIDE CITY LIMITS? YES 2 [X] NO	
n. ansit permit.	FUNERAL	8012 Fingerboa	rd Rd.	•	101	21701			-	N OF WHAT	COUNTRY?	
215-0020 attending physician. se as the burial-transit	₽	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO	NO If yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.						hita, etc,	
=	TED	15. DECEDENT'S ED (Specify only highest grad	UCATION (a completed)	(Give kind of work do	ne durina mo	ON st of working	168	. KIND OF BUSI	NESS/INDUS	TRY		
	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Farmer F	· ,	ed/Painte	2r	Self				
YLAND Spire by the hospital be detached it at once.	O	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	_		umame)			_
	BE C	John Franklin i	Burger			Elizat	eth	Wiles				
, MARYLAND be retained by the hospit ge 5 should be detached e notified at once.	70	190. INFORMANT'S NAME (Type/Print) Mrs. Geraldine	Bwrger	19b. MAILING AODR		ond Number or Flural) 1	
ORE, a 6 may be ector, page must be		20a. METHOD OF DISPOSITION 1	noval from State camet	LACE AND DATE OF DISE ery, crematory or other pla	cel		OAT		ATION — CIT			
Page direc		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE .	derick Men	1071111	Park O ADDRESS OF FA	3/3/	91 Fre	deric	k, MI)	_
BALTIMORE, after death. Page 6 may be noval. moval. cal examiner must be		Marianne	- N. Staus	Her	Stauf P.O.	fer Fune Box 1819	ral Fi	odonic	b. MD	2170	12	
iin 24 nours ely filled in ta nation, or re		23. PART I. Enter the diseases, or shock, or heart feilure IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Myccardin I	Infact CONSEQUENCE OF):	jon			diac or respir	ntory arres	t,	Approximate Interval Betw Onset and De	
P.O. BOX 68 th certificate be execuending physician and I Hygiene prior to bur	CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	Tring Krimin		vej Dis	l'osi					
RECORE requires that the signed by of Health and shows any in	MEDICAL	PART II. Other significent condition	ns contributing to death but	not resulting in the	underlying	g cause given in	Part i.	24a. WAS AN A PERFORM 1 YES 2	IED?	AMA COI OF	RE AUTOPSY FINDIN INLABLE PRIOR TO MPLETION OF CAUS DEATH?	
/ITAL IN: The law Ficate has boots State Dept.	PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ОТН		ACE OF OEATH (Ch	eck only or	ne)		1		
F VIT. SICIAN: The certificate the State I, or item	YSI	1 YES 2 NO	1 Inpatient 2 ER/Outpat	lent 3 DOA 4 D	Nursing Hom	e 5 🗆 Residence						_
NG PHYSI her this c heath with marked,		1 Netural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY		URY AT PRK? YES 2 NO	28d. DES	SCRIBE HOW IN	JURY OCCUP	IED		
DIVISION OF VI. OR ATENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the St. Item 28 is marked, or it	TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify	At home, farm, street,			28f. LOC City	ATION (Street an or Town, State)	d Number or	Rural Route	Number,	
절작업물	COMPLET		SICIAN: To the best of my knowled								d manner aa state	d.
E HOS		296. SIGNATURE AND TITLE OF CERTIFIE	ER .			29c. LICENSE NUI	MBER	T	29d. DATE S	IGNED (Mo	nth, Day, Year)	
D THE HOSPI TO THE FUNER MEMORITANT:	O BE	M	NW			1371	78		▶ 1			
(1)	5	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, Print)	0							
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT			-						_
		MAR 0 3 19	93 Julia wandso	n-Randall								



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

		вгтіт. Pages 1, 2, 3 should		
0200-51212	or attending physician.	or use as the burial-transit p		
DALLIMORE, MARYLAND 21215-0020	NG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		be notified at once.
DALIIMOR	hours after death. Page 6 ma	d in by the funeral director, i	or removal.	d, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
BOY SOLOU,	scate be executed within 24 I	ohysician and completely fille	in the State Dept. of health and Mental hygiene prior to burial, cremation, or removal.	er traumatic event, the
TALALACOADS, P.O. BOA 56/50,	requires that the death certifi	en signed by the attending	of nealth and memai riggier.	shows any injury, or oth.
ON OF VITAL	JING PHYSICIAN: The law r.	After this certificate has be	Death with the State Dept.	8 is marked, or item 23 si
C NICISIANI	D THE HOSPITH OR ATTENU	THE FUNE MI, DIRECTOR:	THE STREET OF LOUIS ARE	MPORTANT: If Item 28 Is

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTING	MENT OF H	EALTH AND I	WENTAL HYGIEI		00000	
	1. DECEDENT'S NAME (First, Middle, Lest)	noderick		BROWN,		2. DATE OF DEATH MONTH	2/27/9	3. TIME OF DEATH 3. 0038 M	
	4. SOCIAL SECURITY NUMBER 111-24-5676	1 💢 M 2 🗌 F	61 YRS. MC	UNDER 1 YEAR	F UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 11,		BIRTHPLACE (State or Foreign Country) New Hampshire	
TO TO	90. FACILITY NAME (If not institution, give Frederick Memo				derick	ATH	1000	of DEATH derick	
DIRECTOR	10s. STATE 10b. COUNT	ntgomery	10c. CITY, T	OWN OR LOCAT	ascus			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	100. STREET AND NUMBER 28428 Clarks	sburg Rd.		101.	20872		10g. CITIZE	N OF WHAT COUNTRY? USA	
à	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EYER II FORCES? 1 EYES IF YES, GIVE WAR OR D	ATES	If yes, spe	ENDENT OF HISPAN Herity Cuban, Mexica 2 A NO Specify	IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	ns or No.— 14	RACE — American Indian, Black, White, etc. Specify: White	
LETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)		ille. Do NOT use re	done during mos tired.)	one during most of working d.)				
COMPLET	12 17. FATHER'S NAME (First, Middle, Last)	f Page m	A	rtist	Graphics 18. MOTHER'S NAME (First, Middle, Meiden Sumeme) Viola Alice Henry			Art	
TO BE	Carlyle 1 190. INFORMANT'S NAME (Type/Print) Mary E. Brown				nd Number or Rural F	house Number, City or Tox , Damascu	vn, State, Zip Co	,	
	20e. METHOD OF DISPOSITION 1	20b	PLACE AND DATE OF CONTROL OF CONT	ISPOSITION (Na	ne of 0 / 3	904TE 20c. L	OCATION — City	y or Town, State da, Md.	
	21. SIGNATURE OF FUNERAL SERVICE LI		L. Mole		.A.				
CERTIFICATION	23. PART I. Enter the diseasea, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	a. DUE TO (OR AS A DUE TO (OR AS A	ach lina. CONSEQUENCE OF: OSCIEVE	res	+			Interval Between Onset and Death	
MEDICAL	PART II. Other algorificant condition	na contributing to death b	ut not resulting in t	ha underlying	cause given in		RMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO	
PHYSICIAN:	25. WAS CASE RESERRED TO MEDICAL EXAMINED	HOSPITAL:		THER:	ACE OF DEATH (CH				
BY PHYS	1 (NET 2 NO 27. MANNER OF CEATH 1 Netural 5 Pending Investigation	28s. DATE OF INJURY (Month, Day, Yeer)	28b. TIME O	F 28c. INJU WOR	IRY AT	8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUP	RED	
	2 Accident Investigation 3 Suicide 8 Could not be determined	28e, PLACE OF INJURY building, etc. (Spec	IY — At home, farm, streat, factory, office			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLEIED		ICIAN: To the best of my know ER: On the beele of examination							
10 05	296. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WI	aprin	ATH (UTEM 27) (Type, Pri		29c. LICENSE NUM	5/83	29d. DATE S	IGNED (Month, Day, Max)	
	31. DATE FILED (MONTH, Day, Year) MAK U 1 19	32. REGISTRAR'S SIGN 35 Sicha ward	ATURE PRODUCE PRO	300	w9	st St	trea	lerick, MD	

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is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at

31. DATE FILED (MONTY, Day, Year)
MAK U1 1993

32. REGISTRAR'S SIGNATURE

Juna invision Mandall

	FOR	OTATE OF .							9	2 0	0009	
	1 - STATE REGISTRAR	STATE OF I	MARYLAND / CI	DEPAR ERTIF	ICATE	OF DEA	H AND I	MENTAL HYGIEN				
}	1. DECEDENT'S NAME (First, Middle, Last)	± 1.5						2. DATE OF DEATH		3.	TIME OF DEATH	
	Albert	Lei		UMENAUER			February 26, 1993 11			11:10 P.		
	214-10-3150	5. SEX 1∭ M 2 ☐ F	6. AGE (In yrs. In:	st birthday) YRS.	MONTHS D	EAR IF UND	MIN.	July 29,	1909	8. BIRTHPLA Country)	CE (State or Foreign ryland	
Œ	9a. FACILITY NAME (If not institution, give si Frederick Memori		+-7			WN OR LOCA		EATH		OUNTY OF DEATH		
010	RESIDENCE OF DECEDENT	ial Hospital Frederick F					Freder	тск				
DIRECTOR	Maryland Fr	rederick Frederick							I. INSIDE CITY LIMITS? X YES 2 NO			
FUNERAL	100. STREET AND NUMBER 402 Wilson Place				***	101. ZIP CO			10g. CIT	IZEN OF WHAT	COUNTRY?	
NE	11. MARITAL STATUS	40 1170 07777				<u> </u>	1701			U.S.		
ВУ	1 Never Merried 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2 XI	IMED NO	If ye	a, specify Cut YES 2/1 NO	an, Maxica	IfC ORIGIN? (Specify Yan, Puerto Rican, etc.)	n or No—	14. RACE — A Black, Wh Specify:	American Indian, nite, atc. White	
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	1 76	irve kind or i	USUAL OCCU	PATION or most of work	tina	18b. KIND OF BU	SINESS/INC	DUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	+) life	Do NOT u	n Make			Tron	hne	Steel	Company	
OM	17. FATHER'S NAME (First, Middle, Last)							ME (First, Middle, Maiden		Dueer	Company	
BE C	John William Blu	menauer						Ann Kline				
10	19a. INFORMANT'S NAME (Type/Print) Catherine A. Blum	enauer	191	b. MAILING	ADDRESS (SI	Place,	er or Rural F	derick, Ma	n, State, Zir	code) nd 217(01	
	20s. METHOD OF DISPOSITION 12 Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACEAND DATE OF DISPOSITION/Name of Cremation 1 DATE 20c. LOCATION — City or Town, State Prederick, Maryland											
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1100110	0 2	22. NAN	E AND ADDR	ESS OF FAI	CILITY				
	Kuhut C.C.	Busfor		0021		Ceeney 106 Ea	and st C	Basford F nurch St.,	Free	derick		
	23. PART i. Enter the diseases, Dr c shock, pr heart failure. I	omplications the	caused the de se on sach lina	ath. Do r	ot enter the	mode of d	ying, auci	n as cardiac or reap	Iratory an	rest,	Approximate Interval Batween	
	IMMEDIATE CAUSE (Final disease or condition	m«		0	5.0	i.					Onsat and Death	
	resulting in death)	DUETO									NIhr.	
N	Concentre land lailure										weeks	
ATIC	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING									18	1	
CERTIFICATION	CAUSE (Disease or Injury that initiated events	DUE TO	OR AS A CONSEC	DUENCE OF	TON	, - r) VC 1 c	crear a			weeks	
ERT	resulting in death) LAST									ļ		
	PART II. Other significant conditions	contributing to	death but not n	eaulting i	n the under	lving cause	alven in i	Part I. 24s. WAS AN	ALITOPSY	245 WED	IE AUTOPSY FINDINGS	
S	Seizure	disord				, ,		PERFOR	MED?	COM	LABLE PRIOR TO IPLETION OF CAUSE	
PHYSICIAN: MEDICAL								_ , _ , _ ,	XNO		YES 2 NO	
ä												
SC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:	6. PLACE OF I	DEATH (Che	ck only one)				
H	27. MANNER OF DEATH	1 Inpetient 2 I		28b. TIM		Home 5 A	esidence	8 Other (Specify) 28d. DESCRIBE HOW I	N III IBV OO	NIBEO		
ВУ Р	Natural 5 Pending 2 Accident Investigation	(Month, Di	iy. Ybar)	LNI	URY	WORK? YES 2	□ NO	200. DECOMBE HOW I	NJOHT OCC	JUNED		
	3 Suicide 8 Could not be detarmined	28e. PLACE OF INJURY — At home, larm, street, factory, offica building, etc. (Specify)				28f. LOCATION (Street and Number or Bural Route Number, City or Town, State)						
PLE	29a. CERTIFIER (Check only CERTIFYING PHYSIC	IAN: To the best of	my knowladge, de	nth occurre	d at the lime,	data and place	, and due	to the cause(a) and mar	ner as stat	ed.		
COMPLETED	One) 2 MEDICAL EXAMINER										manner as stated.	
BE	296. SIGNATURE AND TITLE OF CERTIFIER	12_	10,1	10			ENSE NUM		29d. DATE	SIGNED (Mon	th, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH (ITEN	1 27) (Type	Print)	D	367	0 /	•)-/-	-73'	
	Dr. Sara Hults	sch-Smith	ı, M.D.,	915	Toll	House	Ave.	, Frederic	k, M	arylan	d 21701	

. . .

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, OR ATTENDING

filed within 72 h

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38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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MANAZO, M.D.

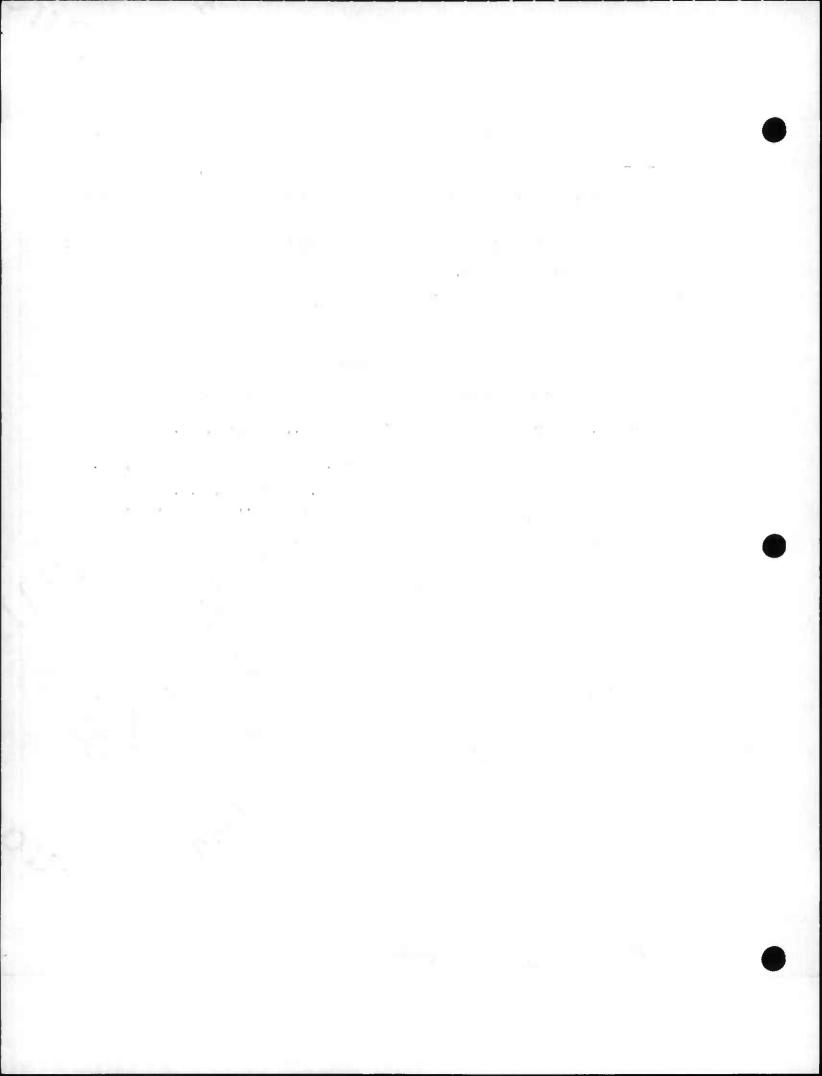
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and distributed the control of the c	ENECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Places 1, 2, 3 signed.	ther (item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notify
2	RECT	Urs a	m 2
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93 08690 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 2. DATE OF DEATH 2/26/9 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2:300 BOYER Elizabeth Susan A SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. (Month, Day, Year) May 14,1905 219-36-7612 87 1 M 2 XF Maryland 9a. FACILITY NAME (If not institution, give street end number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Frederick Memorial Hospital Frederick Frederick RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Damascus 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 26626 Howard Chapel Dr. 20872 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: ВУ 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Educator County School System 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) George Milton Boyer Annie Marie Bowman BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 George C. Cramer 26533 Haney Ave., Damascus, Md. 20872 20s. METHOD OF DISPOSITION
1 🖫 Burlel 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Meth. Damascus 3/1/93 Damascus, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A. Kir 26401 Ridge Rd., Damascus, Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Ithwelestre MEDICAL CERTIFICATION Sequentially list conditions. DUE TO (DR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (DR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY erun 1 TYES 2 NO OF DEATH? 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient | ER/Outpetient | 3 | DOA |
28e. DATE OF INJURY (Month, Day, Year) | 28b. TI EXAMINER? OTHER: 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Accident 5 Pending 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be BE COMPLETED 4 Homicide IMPORTANT: If Item 29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month. Day, Year, Ryn -18191

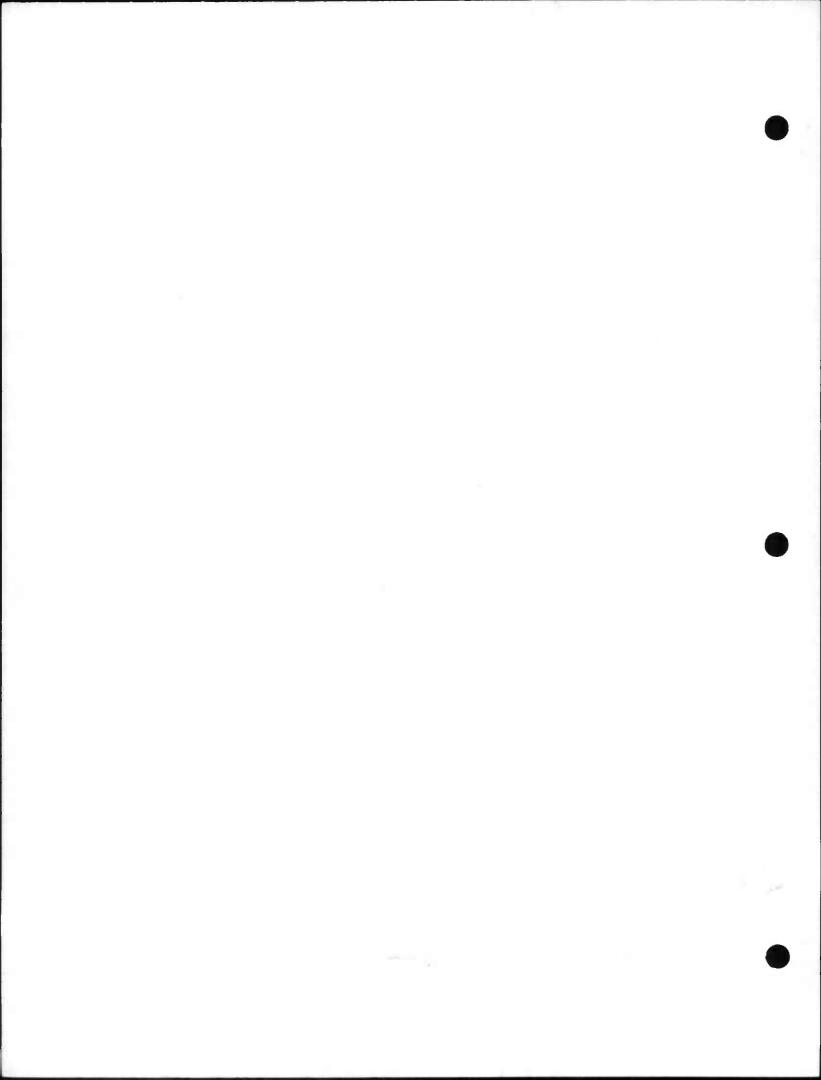
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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within IVISION OF VITAL RECORDS, P.O. BOX 68760,

the state of the s	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit pages 1.2.3 should	are death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal,	then 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
	TOR: After I	after death	28 is mar	
-	AL DIRECT	f hours a	If Item 2	
	E FUNER	The state of	DRIANT	
1	P	20	IMPC	١

	1 - FOR STATE OF REGISTRAR	MARYL	AND / DEPAR CERTIF	TMENT OF	HEALTH AND	MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)	TIICAC	EVERETT				OF OEATH		3. TIME OF DEATH	
	AZAYARANXX XBAXXXXX XBAXX XAXAXX	LUCAS	EVEREII	DKUDAR	EK	FEBR	UARY 2	$\frac{2}{2}$ 4, 199		
1	4. SOCIAL SECURITY NUMBER 5. SEX	IRTHPLACE (State or Foreign								
	None 1 💹 M 2 🗆		YRS.	MONTHS DAY	HOURS MIN.	172	4/93	Ma	aryland	
~	9e. FACILITY NAME (If not institution, give street end number)			9b. CITY, TOW	N OR LOCATION OF I	DEATH		9c. COUNTY C	OF DEATH	
P	THE JOHNS HOPKINS HOSPIT	AL		BALT.	MORE CIT	Υ		BALTI	MORE	
DIRECTOR	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LO	CATION				10d. INSIDE CITY	
	Maryland Frederick		LIMITS?							
A	10e. STREET AND NUMBER	OF WHAT COUNTRY?								
FUNERAL	154 North Willowdale Dr	ive			21701			U.S.	Α.	
2	11. MARITAL STATUS 12. WAS DECER 1 Never Married 2 Merried FORCES?	1 YES	U.S. ARMED	13. WAS D	ECENDENT OF HISPA specify Cuben, Maxic	NIC ORIGIN	? (Specify Yes	or No— 14. R	RACE — American Indian, Black, White, atc.	
À		E WAR OR D			ES 2X NO Spec		10411, 4(0.)		White	
	15. DECEDENT'S EDUCATION		16a. DECEOENT'S	USUAL OCCUP	ITION	106	KINO OF BUIL	SINESS/INDUSTR		
E	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or	(5+)		vork done during			Turvo or Bot	JINESS/INDOSTA		
APL	None	.,	Infar	nt						
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N	AME (First, A	fiddle, Maiden	Sumeme)		
BE	Britt Alan Brubaker				Terri					
2	19e. INFORMANT'S NAME (Type/Print)				et end Number or Rura					
	Britt A. Brubaker								Maryland 2170	
i	1 M Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b	PLACE AND DATE OF OFFICE OF OFFICE OF OFFICE	F DISPOSITION har placa)	(Name of	DATE		CATION — City o		
	21. SIGNATURE OF FURERAL SERVICE LICENSEE	1 MC	ount/Uliv	-	AND ADDRESS OF F		Fre	derick,	Maryland	
	V Delay 19	Vack	1/5				SON	FUNERAL	HOMES, P.A.	
-	22 Charles the discourse	ey	1/	1201	NORTH MA	ARKET	ST. F	REDERIC	CK, MD 21701	
	22. PART I. Enter the diseases, or completations shock, or heart fallure. Lief only the	canse ou e	ithe death. Do n agn line.	Dt enter the i	node of dying, su	ch as csrd	isc or respi	ratory arrest,	Approximate interval Between	
}	disease or condition									
ł	resulting in death)	Sa.								
-	PUT TO (OR AS A CONSEQUENCE OF): HCIDOS IS, Bradylacha.									
<u> </u>	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):									
3	CAUSE (Disease or injury	MON	ONARY INTERSTIAL E				PHYS	EMA.	1/2 W.	
E									301	
CERTIFICATION	d	4114	HRAGMATIC HERNI						50d.	
A I	PART ii. Other significant conditions contributing	to death b	ut not resulting i	n the underly	ing cause given in	Part I.	24s. WAS AN		24b. WERE AUTOPSY FINDINGS	
	In eumotheraies.						1 YES 2		AMAILABLE PRIOR TO COMPLETION OF CAUSE	
WE									OF DEATH? 1 YES 2 NO	
ÿ.										
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:			26. OTHER:	PLACE OF DEATH (C	heck only on)			
Ϋ́S		_	etlent 3 DOA	4 - Nursing H	ome 5 - Residence	1				
		OF INJURY , Day, Year)	28b. TIME	JRY	NJURY AT WORK?	28d. DES	CRIBE HOW I	NJURY OCCURED	,	
À	2 Accident Investigation 3 Suicide 6 Could not be 28e. PLACE	E OF INJURY	— At home, tarm, s		YES 2 NO	284 1 004	TION (Steel	and Mumbes on Du	- 10	
	4 Homicide determined building	ng, atc. (Spec	ify)	neer, ractory, or	no e	City o	r Town, State)	and Number or Rui	rai Houte Number,	
COMPLETED	29e. CERTIFIER	ad any bassard	4 4 4							
29e. CERTIFFIER (Check only one) 1 CERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end dua to the ceuse(e) end manner as attated. 2 MEDICAL EXAMINER: On the basia of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner as at									te(s) and manner as stated	
	29b. SIGNATURE AND TITLE OF CERTIFIER.			, , , , ,			end place, en			
H H	Sha a Tehelle	~			29c. LICENSE NU	MBEH		29d. DATE SIGN	VED (Month, Day, Year)	
유	30. NAME AND ADDRESS OF PERSON WHO COMPLETED C	SE OF DE	ATH (ITEM 27) (Type,	Print)	10-17	ر ر			1-1112	
	Johns Haplins	NIC	eu.	Joh	Il son	phe	in A	ornio	2	
		RAR'S SIGN				-				
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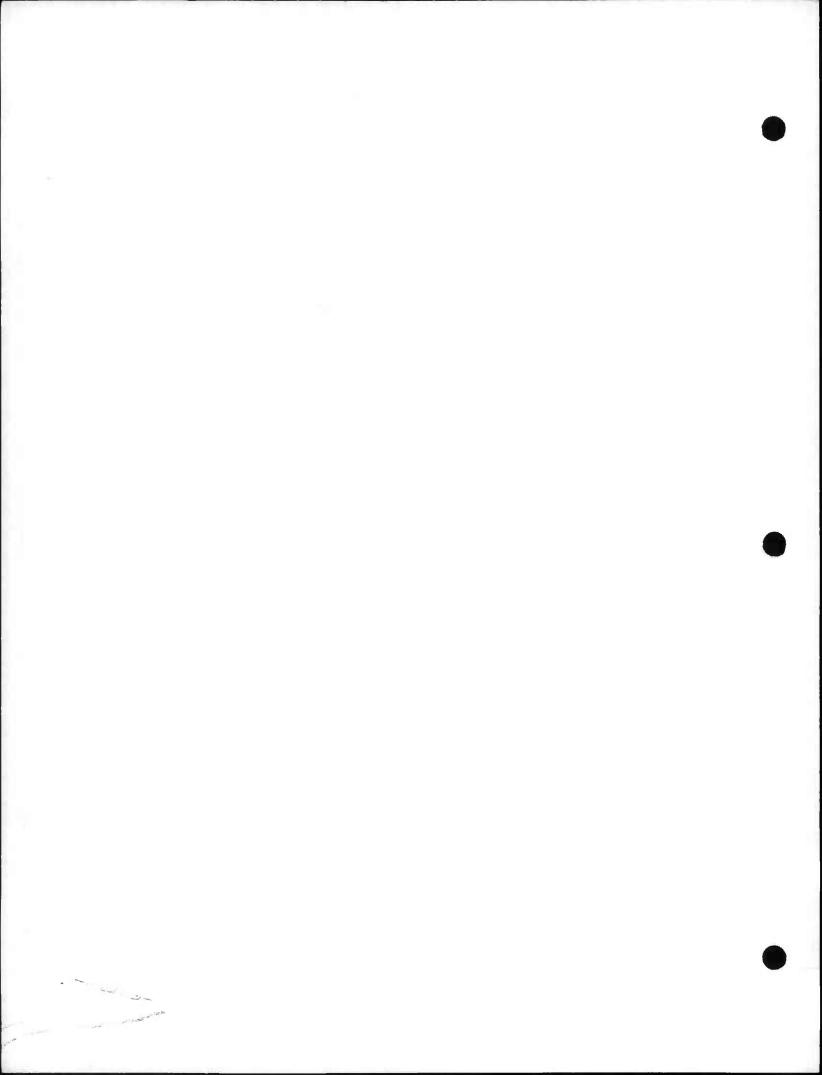
THE USPAIL OR ATTENDING PHYSICATE. The law requires that the death certificate be executed within 2× hours after death. Page 6 may be retained by the hospital or attending physician.

TO VIAE FUNETAR DIRECTOR. After this certificate has been signed by the standing physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, chamation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

STATE	0F	MARYL	AND .	DEPART	TMENT O	FH	EALTH	AND	MENTAL	HYGIE	NE
			C	ERTIFI	CATE (OF	DEAT	H		REG. N	10.

	1 - FOR STATE OF MARYL REGISTRAR		ENT OF HEA		ITAL HYGIENI REG. NO.	E					
	1. DECEDENT'S NAME (First, Middle, Last)				DATE OF DEATH		3. TIME OF DEATH				
	Mary Elizabeth Bo	wman			arch 13	YEAR 1993	740am m				
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE			UNIDER 24 HRS. 7, C	ATE OF BIRTH	8. BIRT	HPLACE (State or Foreign				
	428-48-9686 ¹□м²¬₽F	67 YRS.		03	Morith, Day, Year)	926 Ma	aryland				
~	9a. FACILITY NAME (If not institution, give street and number)	9b		DCATION OF DEATH		9c. COUNTY OF	DEATH				
BY FUNERAL DIRECTOR	310 Maryland Avenue		Ridgely			Carol					
Ä	10a. STATE 10b. COUNTY	10c, CITY, TO	OWN OR LOCATION			10d. INSIDE CITY					
	Maryland Caroline			Ridge	ly	LIMITS? 1 XYES 2 NO					
RAI	10e. STREET AND NUMBER 310 Maryland Avenue		10f. ZIP		_	10g. CITIZEN OF WHAT COUNTRY?					
NE I	11. MARITAL STATUS 12. WAS DECEDENT EVER	N U.S. ARMED	13. WAS DECEND	2166 ENT OF HISPANIC OF		U.S.A.					
F	1 Never Married 2 Merried FORCES? 1 YES	2 NO	If yes, specify	Cuban, Mexican, Pu		Blee	ACE — American Indian, lack, White, etc.				
	3 Widowed 4 Divorced			g no openy.			icasian				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USL (Give kind of work life. Do NOT use re	done during most of	working	16b. KINO OF BUS	INESS/INDUSTRY					
PLE	Elementary/Secondary (0-12) College (1-4 or 5+) 11 yrs.HS grad.	Private	·	omnania	n Hoo	1+h Ca	×0				
NO	17. FATHER'S NAME (First, Middle, Last)	TITVACE		MOTHER'S NAME (F		1th Ca	re				
	Stephen Franklin Lync	h		The second secon	ne Brow		ot.t.				
) BE	19a. INFORMANT'S NAME (Type/Print)		ORESS (Street and N	lumber or Rural Route			-				
2	Beverly M. Ringgold	310 Ma	aryland	Avenue	, Ridge	ly, MD	21660				
		b. PLACE AND DATE OF D		1	DATE 20c. LOC	CATION — City or T	own, State				
	1) Burial 2 Gremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF PUNERAL SERVICE LICENSEE Commetery, crematory or other place) Denton Cemetery 22. NAME AND ADDRESS OF FACILITY										
	21, SIGNATURE OF FOREFALL SERVICE LECENSEE			Funera		P.A.					
	- Rando Jan Mila	one	Drawe	r B, De	nton, M	arylan	d 21629				
	23. PART L Enter the diseases, or complications that cause shock, or heart fallure. List only one cause on a	d the death. Do not each line.	enter the mode of	of dying, such as	cardiac or reapir	ratory arreat,	Approximate interval Between				
	iMMEDIATE CAUSE (Final disease or condition	L. 44 72	sacrut.	CA			Onset and Death				
	disease or condition resulting in death) a. Metastat's TSseart CA Due to (or as a consequence of):										
z											
CERTIFICATION	Sequantially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
S	cause. Enter UNDERLYING CAUSE (Disease or Injury										
Ē	that initiated events resulting in death) LAST	A CONSEQUENCE OF):									
	d										
¥.	PART il. Other significant conditions contributing to death i	out not resulting in the	ne underlying ca	use given in Part	i. 24s. WAS AN A PERFORE		b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO				
Ö					1 TYES 2	NO	COMPLETION OF CAUSE OF DEATH?				
Σ							1 TES 2 NO				
AN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE	OF DEATH (Check or	alv one)						
Sic	EXAMINER 1 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Out		HER:	Residence 6 🗆							
PHYSICIAN: MEDIC	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c INJURY		DESCRIBE HOW IN	JURY OCCURED					
BY	Action Investigation		M 1 TES	2 NO							
	3 Suicide 6 Could not be datermined 28e. PLACE OF INJUR building, etc. (Spe	 At home, farm, stree city) 	t, factory, office	281.	LOCATION (Street er City or Town, State)	nd Number or Rural	Route Number,				
	29a. CERTIFIER		una Toses		and the same of the	- 1747					
3 Suicide 6 Could not be determined City or Youn, State) 29a. CERTIFUE PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 29b. LOCATION (Street and Number or Rural Route Number, City or Youn, State) 29c. LOCATION (Street and Number or Rural Route Number, City or Youn, State)											
E C	296. SIGNATURE AND TITLE OF CERTIFIER	<u> </u>		LICENSE NUMBER			D (Month) Day, Year)				
1 CO	- Marlene a Bue	lechr L	M)	D4150	03	· 3/1	5/93				
٩	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type, Prin	30Pm.	ual	~ /	Λ/	10 21/20				
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGN	(TIL)	U WY	476	Lende	en 1	W 21617.				
	J. Davidso	n-Rands 00									
	1	Y Marilance									



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physician.	ir this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit		
or attending p	use as the		
3 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or after	letached for		once.
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retained	5 should		arked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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STATE	0F	MARYLAND	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIEN	E
		C	ERTIFICATE	O	F DEAT	THE		REG NO	

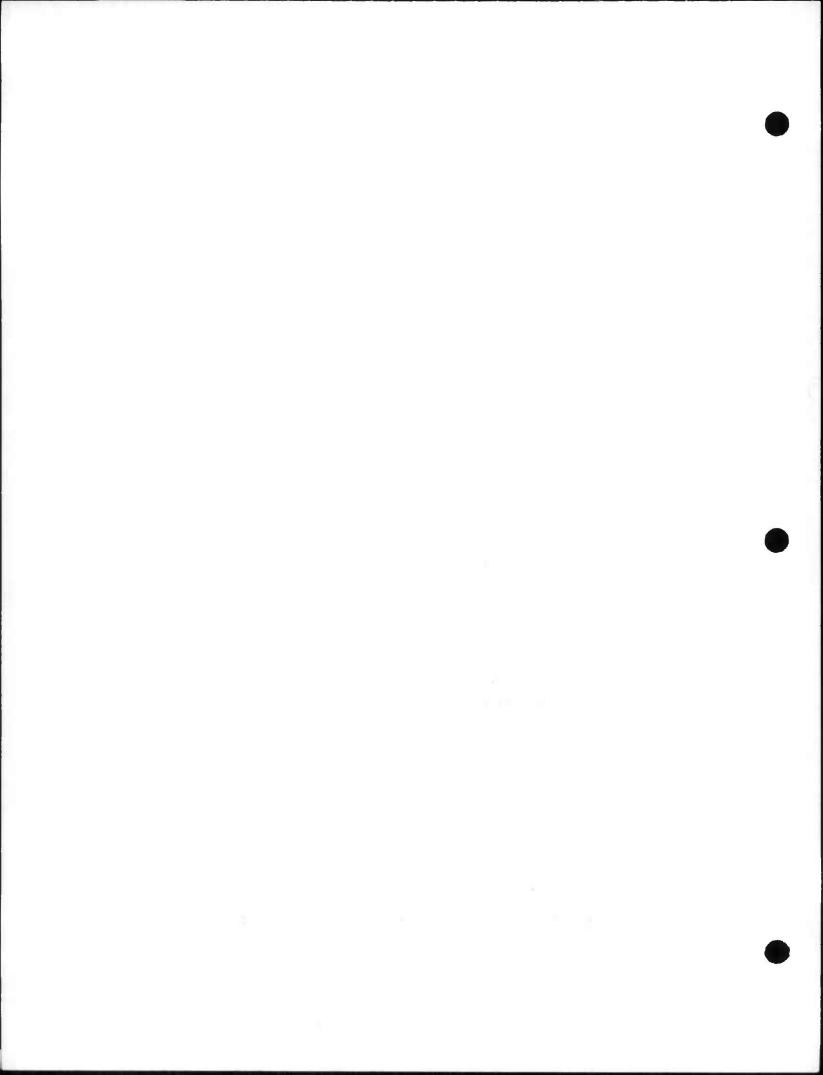
	FOR STATE REGISTRAR	STATE OF MARYLANI	D / DEPARTM			MENTAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) Belle		Bledsoe			2. DATE OF DEATH MONTH MORICH 9	1993 YE	3. TIME OF DEATH	
		6. SEX 6. AGE (In yrs		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug 18, 19	6.1	BIRTHPLACE (State or Foreign Country)	
	9e. FACILITY NAME (If not institution, give street		9c. COUNTY	Virginia OF DEATH					
OR	3528 Bittle Road			Frede	rick				
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. CITY, TO			10d. INSIDE CITY LIMITS?			
	Maryland Frede	rick	Myers		·			1 YES 2 NO	
FUNERAL	3528A Bittle Road				21773			OF WHAT COUNTRY?	
CNE	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2	S. ARMED			IIC ORIGIN? (Specify Yea n, Puerto Rican, etc.)		RACE — American Indien, Black, White, etc.	
BY F	1 Never Merried 2 X Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 TYES				Specify: White	
	15. DECEDENT'S EDUCA (Specify only highest grade co	TION 164	. DECEDENT'S USU	JAL OCCUPATIO	N et of working	16b, KIND OF BUS	SINESS/INDUST		
		College (1-4 or 5+)	Homemak	tired.)		Own Ho	me		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)		
BE C	William Delph					a Reed			
2	190. INFORMANT'S NAME (Typo/Print) Emory Bledsoe					Route Number, City or Town rsville, M			
	20a, METHOD OF DISPOSITION 1 ABuriel 2 Cremetion 3 Remov		ACE OF DISPOSITIO	ON (Name of cen	etery, crematory or			or Town, State	
	4 Donation 6 Other (Specify)	Ula	"Shady M					e, Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LICEI	ISEE ,			D ADDRESS OF FA	ral Home		in Street	
	23. PART I. Enter the diseases, or co	eckette	e deeth Do not						
	shock, or heart failure. Li	st only one cause on each	line.	enter the mo	de oi dying, suc	n sa cerdiac or respi	ratory strest	interval Between Onset and Death	
	immediate Cause (Fine) disease or condition resulting in death) s. Cardwar Arrest							2 house	
_	DUE TO (OR AS A CONSEQUENCE OF):								
TION	if any, leading to immediate Due to (or as a consequence of):								
ICA	CAUSE (Disease or injury								
CERTIFICATION	that initiated events resulting in death) LAST	542 .0 (6.1 AS A 66.	NOCOGENOE OV J.						
AL CE	PART II. Other significant conditions	contributing to death but r	not resulting in t	he underlying	cause given in	Part I. 24a, WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS	
						PERFOR	L W	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
ME	-				(_		1 TES 2 NO	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			26 Pi	ACE OF DEATH (Ch	eck only one)			
SICI	EXAMINER?	HOSPITAL:		THER:		8 Other (Specify)			
PHY	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME O	y wo	RK?	26d. DESCRIBE HOW I	NJURY OCCUR	ED	
ВУ	2 Accident Investigation	28e. PLACE OF INJURY —	At home, farm, stree	M 1 1		28f. LOCATION (Street	end Number or	Rural Route Number.	
旦	4 Homicide 6 Could not be	building, etc. (Specify)				City or Town, State)			
PLE		IAN: To the best of my knowledg	e, death occurred a	nt the time, date	end place, end dua	to the cause(a) and ma	nner sa stated.		
COMPLETED		On the basis of exemination en	d/or investigation, i	n my opinion, d			nd due to the c	ause(s) and menner ee stated.	
BE	296, SIGNATURE AND TITLE OF CERTIFIER,	Dieren M.	D		29c. LICENSE NUI	291	29d. DATE S	IGNED (Month, Day, Year)	
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) (Type, Pri	int)	1010	M	elle	1 9	
	COMICES /CC	wieren m		אקרו	un II	Myerou	wille	Md 21773	
	MAR II 1993	32 REGISTRAR SIGNATU)						

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be retained by the hospital or attending physician. je 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should BALTIMORE, MARYLAND 21203-3146

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,	DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE,	BALTIMORE, MARYLAND
_	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2. Are after death, Page 6 may be retained by the hospital properties of the properties o	e 6 may be retained by the ho
	DARKE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to the state of the funeral director, page 5 should be detached by the state of the funeral directors. The state of the funeral directors are death with the State Dent of Health and Mental Hoders prior to build. Cremation, or removal.	ector, page 5 should be detac
	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	must be notified at once

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC			MENTAL HYGIEN			
	1. OECEDENT'S NAME (First, Middle, Last) Harry J. 1	Harry James BISER	Biser			2. DATE OF DEATH MONTH D		3. TIME OF DEATH 5:50 P M	
ĺ			in yrs. lest birthday) I	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	0.1	BIRTHPLACE (State or Foreign	
ŧ	717-07-9271	⊠ M 2 □ F	99 YRS. MG	ONTHS DAYS	NOURS MIN.	(Month, Day, Year) Oct. 29.	1893 Pennsylvania		
	9e. FACILITY NAME (If not institution, give street	and number)	9	b. CITY, TOWN O	R LOCATION OF DE		9c. COUNTY		
۱ ۶	Ravenwood Luthe	e	Hage	rstown		Was	hington		
	RESIDENCE OF DECEDENT							To a succession of the success	
	100. STATE 10b. COUNTY Maryland Washi		rown on Locat Hagerst				10d. INSIDE CITY LIMITS?		
3	10e. STREET AND NUMBER				ZIP CODE		10a CITIZEN	1 YES 2 NO OF WHAT COUNTRY?	
	860 Virginia Aven	1110		101.	21740			.A.	
		. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC		IIC ORIGIN? (Specify Ye		RACE — American Indian.	
-	1 Never Merried 2 Merried	FORCES? 1 YES	2 X NO	If yes, spe		n, Puerto Rican, etc.)		Black, White, atc.	
5	3 🔯 Widowed 4 🗌 Divorced			1	7.00			specify: white	
] [15. DECEDENT'S EDUCATI (Specify only highest grade con	ION npleted)	18e. DECEDENT'S US (Give kind of wor	k done durina mo:	N st of working	16b. KIND OF BL	ISINESS/INOUS	TRY	
		College (1-4 or 5+)	Illie. Do NOT usa i			rai	lroad		
	0-6		Shop	supervi					
3	17. FATHER'S NAME (First, Middle, Last)	known			18, MOTHER'S NA	ME (First, Middle, Melder Cora B:	iser Br	van	
4	19e. INFORMANT'S NAME (Type/Print)	CITOWII	19h MAII ING A	DDRESS (Street a	nd Number or Burel F	Route Number, City or Tox			
2	Mrs. M. Helen Cott	rill						Maryland 21742	
- 1	20e. METHOD OF DISPOSITION		D. PLACE OF DISPOSIT					or Town, State	
	1 La Burlet 2 Cremetion 3 Removal 4 Donetion 5 Other (Specify)	f from State	Rest Have	n Cemet	ery			m, Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LICENS		Polic je		D ADDRESS OF FA	CILITY Min	nich Fu	ineral Home	
	1 150 x 0 x 1	7)); "	W. C.	415 Ea	st Wilso	n Blvd.,	Hagerst	own, MD 21740	
MOLINGIA	Onset and Deal disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST Onset and Deal Onset and							Criset and Death	
MEDICAL CE	Alzteiner	TI. Other algorificant conditions contributing to deeth but not resulting in the				Part I. 24a. WAS A PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
-									
3		IOSPITAL:		OTHER:	ACE OF DEATH (Ch				
PHTSICIAN.	1 VES 2 NO 1	28e, DATE OF INJURY		Nursing Hon		8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCU	PED.	
Ļ	1 Netural 5 Pending	(Month, Day, Year)	INJUI	RY WO	PRK?	280. DESCRIBE NOW	INJUNY OCCU	NED	
0	2 Accident Investigation	28e. PLACE OF INJUR	Y — At home, term, atr			281. LOCATION (Stree	t and Number or	Rural Route Number,	
ם ב	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Spi	eclfy)	•		City or Town, Stat	9)		
3 Suicide 8 Could not be determined Suicide Su									
	190. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU			IGNED (Month, Day, Year)	
0 05	200	77-0-0	- m	-5	Dag	1262	12	Mar of 1993	
_	38. NAME AND AGORESS OF PERSON WHO	COMPLETED CAUSE OF D	EATH (ITEM 27) (Type, I		N 21	740			
	31. MAR 1993 8	32. PENSTRANT SA	- A						



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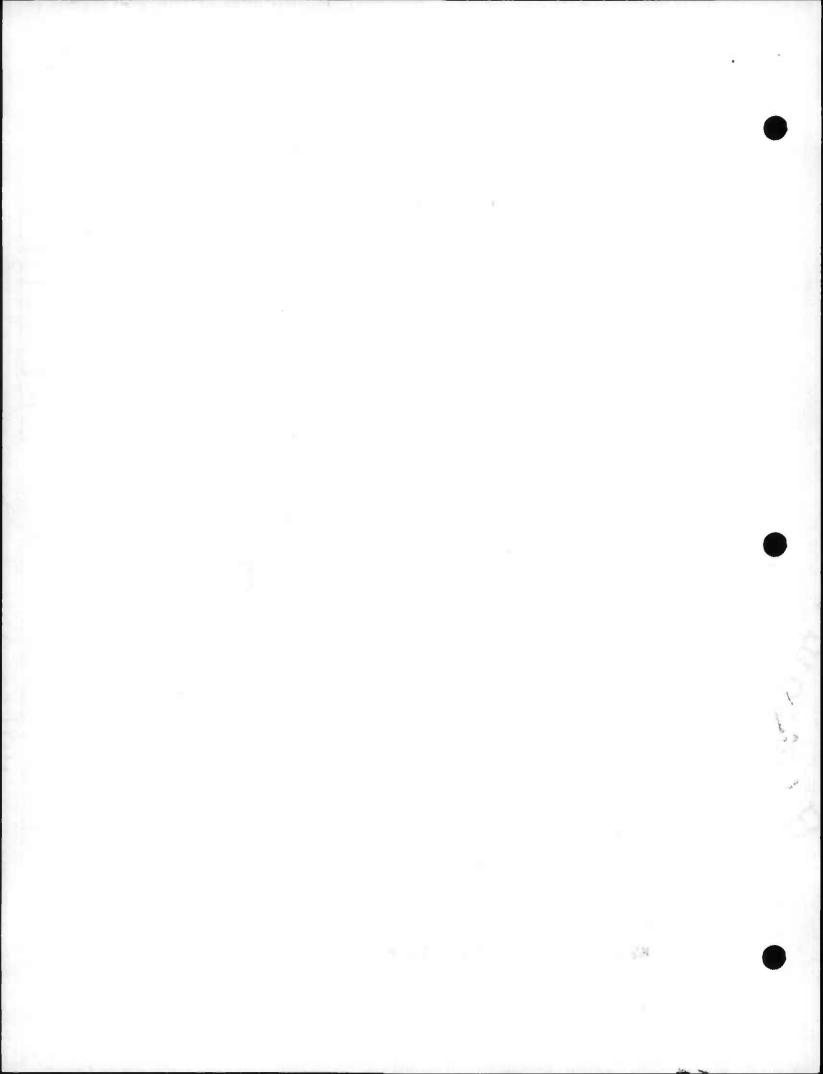
MAR 1 7 '93

		des 1, 2, 3 should		
2000	or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		
	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ctor, page 5 should be detached for		must be notified at once.
	within 24 hours after death. Page	pletely filled in by the funeral dire	cremation, or removal.	WPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	he death certificate be executed	the attending physician and com	ith the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	njury, or other traumatic ev
	SICIAN: The law requires that the	certificate has been signed by 1	the State Dept. of Health and	f, or item 23 shows any in
	HOSPITAL OR ATTENDING PHYS	FUNERAL DIRECTOR: After this	fled Within 72 hours after death with	TANT: If item 28 is marked
	AT OF	10 THE	be filed	IMPOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH BROWL 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Ybar) 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 28-390 DAYS HOURS 1 🗌 M 2 🙀 F 79 VA _93 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Fallston a Harford RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD Harford Aberdeen, MD 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 39 Liberty ST 21001 USA 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No If yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 2 XNO 1 Never Married 2 Married В 1 TYES 2 NO NO Specify 3 Widowed 4 Divorced Black COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 166, KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 11 maid be notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Ferguson BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Lois Jordan Liberty St. MD 21001 Aberdeen 20e. METHOD OF DISPOSITION
1 | Burlel 2 | Cremetlen 3 | Ren
4 | Donation 5 | Other (Specific 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must cemeter crematory or other prace Baltimore, MD examiner 22. NAME AND ADDRESS OF FACILITY Arnold Beard Funeral Service Box 188 Havre de Grace medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heart fellure. List only pro-cause on each lina. **IMMEDIATE CAUSE (Finel Onset and Death** disease or condition reaulting in death) PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificant conditions contributing to deeth but not reculting in the undarlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24e. WAS AN AUTOPSY 1 TYES NO. OF DEATH? 1 - YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 N Inpatient 2 - ER/Outpatient 3 - DOA 1 TYES 2 NO OTHER: ne 5 🗆 Residence 6 🗆 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investiga ВУ 1 YES 2 NO Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building: etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be datermined COMPLETED 4 Homicide CERTIFIER (Check only one)

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated. 29b. SIGNATURE AND BE 29d. DATE-SIG ED /M 2 PEATH (ITEM 27) (Type, Print) rejuci 0 32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day,

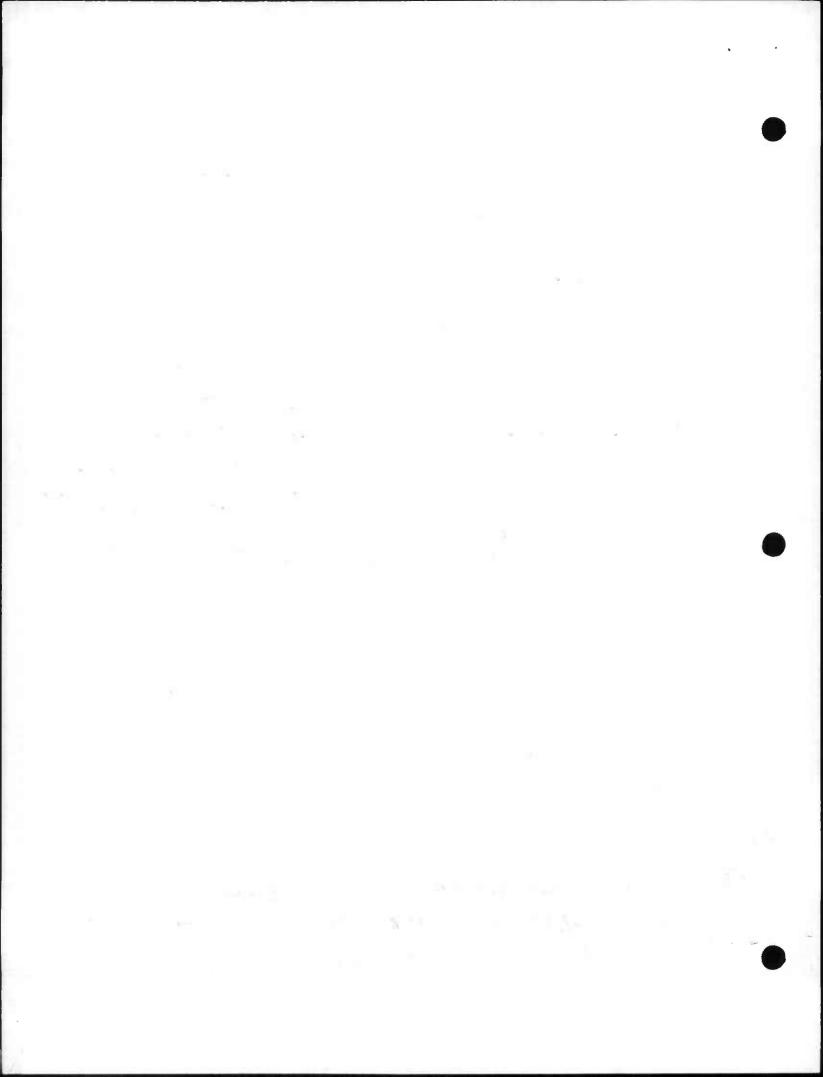
whe Savidson Randelle



JIVISION OF VITAL RECORDS, P.O. BOX 68760,

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	1 - STATE REGISTRAR	STATE OF MA	RYLAND / DEPAR CERTIF	TMENT OF HEA		ENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)		ROSE ROM	Y BURGES	S	2. DATE OF DEATH	3. TIME OF DEATH	^
		ush R	urgess			MONTH DV	7 93 7:15	M
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birthday)		UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)	gn
	217-74-8238	1 🗆 M 2 🔀 F	86 YRS.			Dec. 8,190		
OR	9a. FACILITY NAME (II not institution, give a Harford Memor	Tal Hosp	ital	Havre	A /		BC. COUNTY OF DEATH /	
<u>[</u>	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	· /	10c CIT	Y. TOWN OR LOCATION			10d, INSIDE CITY	
L DIRECTOR	Maryland Ha	arford		hurchville			1 TYES 2 NO	0
FUNERAL	2614 Palmyra Dr.			10f. ZIP	21028		10g. CITIZEN OF WHAT COUNTRY? USA	
2	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT E				ORIGIN? (Specify Yes Puerto Rican, etc.)	or No— 14. RACE — American Indian, Black, White, etc.	
B	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR			NO Specify:	Toolio mani, easy	specify: White	
ETED	15. DECEDENT'S EDU (Specify only highest grade		(Give kind of	USUAL OCCUPATION work done during most of	working	16b. KIND OF BUS	SINESS/INDUSTRY	
COMPLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	House			****	-	
8	17. FATHER'S NAME (First, Middle, Last)			18.	MOTHER'S NAME	E (First, Middle, Maiden	Surname)	
B B	James Edward	Horn			Lydia		Gray	
٤	19a. INFORMANT'S NAME (Type/Print) Robert Ca Burgess	s, Sr.		Palmyra Dr			· · · · · · · · · · · · · · · · · · ·	
	20a. METHOD OF DISPOSITION 1 M Burlal 2 Cremation 3 Rem	oval from State	206 PLACE AND DATE	OF DISPOSITION (Name of	f	DATE 20c 10	CATION — City or Town, Stata	
	4 Donation 5 Other (Specify)		Lorraine	Park Cemet	ery 3-	20-93 B	altimore. Md.	
	21. SIGNATURE OF FUNERAL SERVICE LIC	M. D.		22. NAME AND AI Howard	K. McCc	omas III E	uneral Home, P.A.	
	23. PART i. Enter the diseases, pr	complications that co	V(QA) 666	1317 CC	okesbury	7 Rd., Abi	ngdon, Md. 21009	
	shock, or heart fallure.							
shock, or heart fallure. List only page cause on each line. IMMEDIATE CAUSE (Final						ar out also of roups	Interval Between	ween
	IMMEDIATE CAUSE (Final disease or condition	List only boe cause	on each line.				Interval Between Propert and Pro	ween
	IMMEDIATE CAUSE (Final	. ART	on each line.	CLEIW			Interval Between	ween
NO	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	a. AR 7 DUE TO (OF	DO EACH III.	CLEIN.			Interval Between Propert and Pro	ween
ATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. AR 7 DUE TO (OF	EPLOS	CLEIN.			Interval Between Propert and Pro	ween
FICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	a. ART DUE TO (OR	DO EACH III.	CLE W. F):			Interval Between Personal Pers	ween
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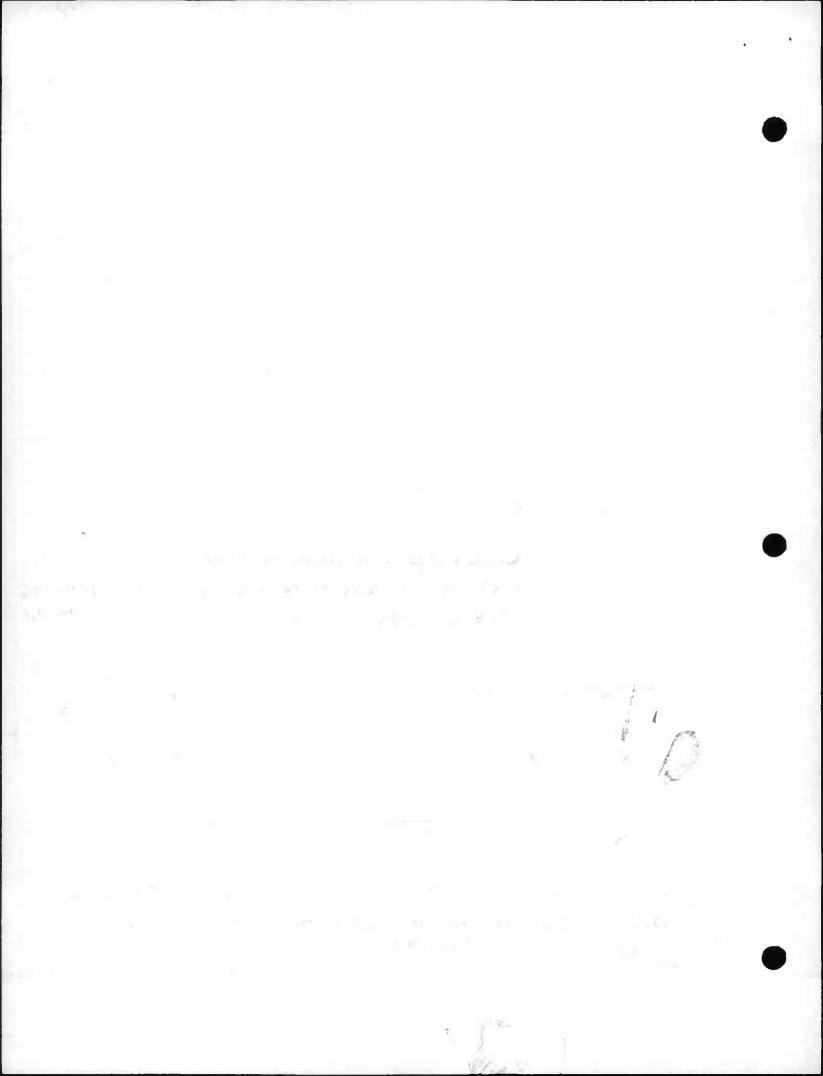
ENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	R: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be detached for use as the bunial-transit permit.	
ITENDING PHYSICIAN: Th	CTOR: After this certificate after death with the State	tem 28 is marked, or item
ACTHE HOSPITAL OR	TO THE FUNERAL DIRE	IMPORTANT: If Item

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF		MENTAL HYGIEN		00001	
	1. DECEDENT'S NAME (First, Middle, Last)	Barnes				2. DATE OF DEATH DO NONTH	î 9'	3. TIME OF DEATH A	
	214-36-8025	1 № 2 □ F 5	(In yrs. last birthday) 7 YRS.	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 11/10/4		BIRTHPLACE (State or Foreign Country) Maryland	
TOR	T 11 1	neral Hos	50.	Falls	or location of d ston	DEATH	9c. COUNTY	SGC CL	
DIRECTOR	10s. STATE 10b. COUNTY	rford		reet	ATION			10d. INSIDE CITY LIMITS? 1 YES 2 X NO	
FUNERAL	100. STREET AND NUMBER 3103 Anna Drive				101. ZIP CODE 21154			S.A.	
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 XNO	If yes,	ECENDENT OF HISPA apacify Cuban, Mexico ES 2 XNO Specia	NIC ORIGIN? (Specify Yes an, Puerto Rican, etc.) ify:	s or No — 14.	RACE — American Indian, Black, Whita, atc. Specify: Black	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	Completed) College (1-4 or 5+)	(Give kind of life. Do NOT u		TION most of working	16b. KIND OF BU		TRY	
OMP	12 17. FATHER'S NAME (First, Middle, Last)	0	Pipe fi	itter	44 MOTHEDIS N	Pipe Mai		uring	
-	John Daniel Barr	nes				AME (First, Middle, Melden Irene Wat			
BE	19a. INFORMANT'S NAME (Type/Print)	1100	19b. MAILIN	G ADDRESS (Stree		Route Number, City or Tow		ode)	
임	Mr. Stephen E. Ba	arnes				eet, Maryl		1154	
	20e. METHOD OF DISPOSITION 1 M Burlel 2 Cremetton 3 Remove 4 Donation 5 Other (Specify)	val from State	petery cremetory or of Larks Uni	OF DISPOSITION /	Name of	OATE 20c. LC			
	21. SIGNATURE OF FUNERAL SERVICE LICE	Liovan	mi	22. NAME Tal	and address of Farring-Cardeen, Ma	go Funeral aryland 2	Home,	P.A. 399	
	23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ehock, or heert feliure. Liet only one ceuse on each line.								
	immediate cause (Final disease or condition resulting in death)								
NO	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): EXTENSIVE NON-HOXEKIN LYMPHOMA 15 DUE TO (OR AS A CONSEQUENCE OF): 2.6 EXTENSIVE NON-HOXEKIN LYMPHOMA 15								
CATIC	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury			1 4	ome	,		2 months	
CERTIFICATION	that initiated events resulting in death) LAST	J	A CONSEQUENCE O	F):					
PHYSICIAN: MEDICAL		PART II. Other significant conditions contributing to death but not resulting in the RPES ZOSTER,					AUTOPSY RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 XNO	
AN	25. WAS CASE REFERRED TO MEDICAL			24	PLACE OF DEATH (C)				
Sic	EXAMINER?	HOSPITAL:	netlant 3 DOA	OTHER:					
H	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIN	ME OF 28c. I	ome 5 Residence	8 ☐ Other (Specify) 28d. OE\$CRIBE HOW	NJURY OCCUR	REO	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	IN.		WORK? YES 2 NO				
a	3 Suicide 6 Could not be 4 Homicide datarmined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm,	street, fectory, of	fice	281. LOCATION (Street City or Town, State,		Rural Route Number,	
COMPLET		CIAN: To the best of my knowl R: On the basis of examination						ause(a) and manner as stated.	
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	-	mo		29c. LICENSE NU	SS6	29d. DATE SI	IGNED (Month, Day, Year)	
1	30. NAME AND ADDRESS OF PERSON WHO	mu R	DHE	BEL	camp	mo s	2/01-	7	
	31. DATE FILEO (Month, Day, Year) MAR 15 93	32. REGISTRAR SHIGH	June Binds	102					

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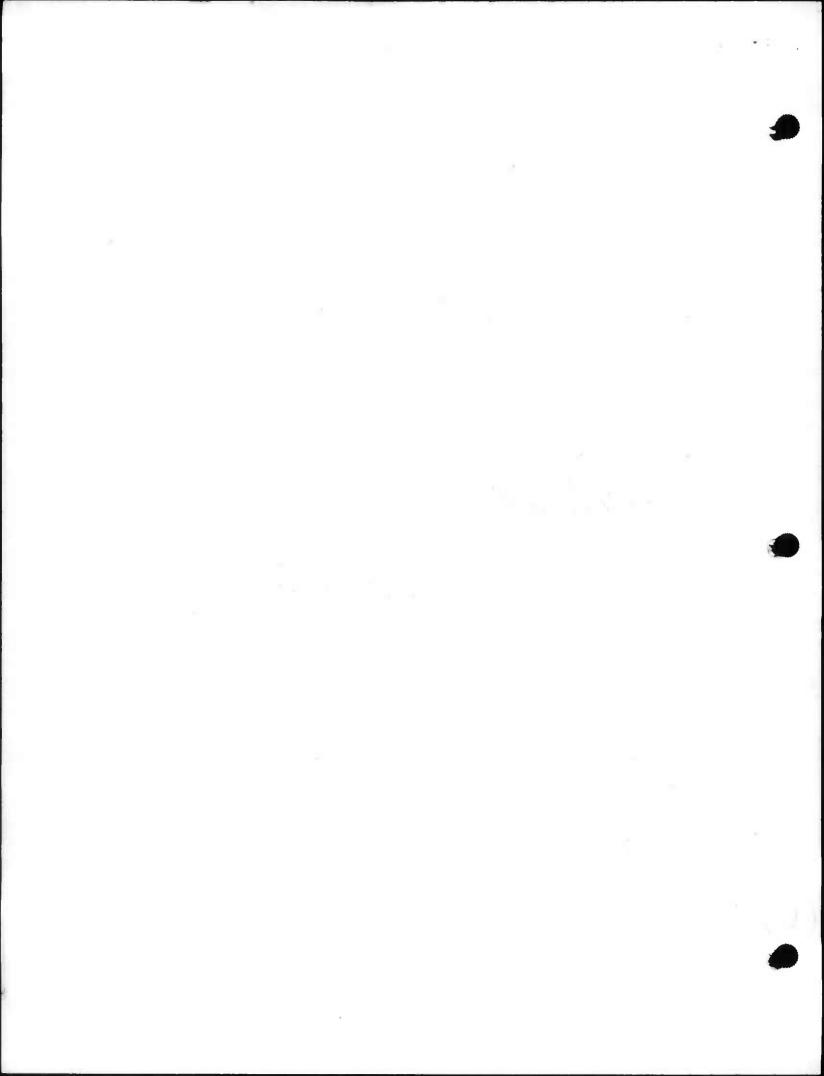
93



IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE	0F	MARYLAND	I	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
		C	E	RTIFICATE	O	F DEAT	TH		REG. NO.

	FOR STATE REGISTRAR	STATE OF MARYI	AND / DEPAR CERTIF					ENTAL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	ANN B	YRNE					2. DATE OF DEATH DAY	,	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER	4 WEAR	IF UNDER 24	11000	3-14-93 7. DATE OF BIRTH		e BIETUE	5:00 AM M
	100 00 1000		92 YRS.	MONTHS	DAYS	7	MIN.	(Month, Day, Year) 12-23-0	n	8. BIRTHPLACE (State or Foreign Country) Canada	
	9a. FACILITY NAME (If not institution, give stre			9b. CITY,	TOWN O	R LOCATION	OF DEA		9c, COUNTY OF DEATH		
5	9202 W. Biscayne		0	cean	City	,		Wo.	rcest	er	
2	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY					ON					10d. INSIDE CITY
DIRECTOR	Md. Wo	rcester		Ocean							LIMITS?
UNERAL	10e. STREET AND NUMBER 9202 W. Biscayn	ne Dr.				ZIP CODE 21842				IZEN OF WI	HAT COUNTRY?
מטי זם	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 X NO	1	yes, spe		Mexican,	C ORIGIN? (Specify Yea Puerto Rican, etc.)	or No—	14. RACE Black, Specify	- American Indian, White, etc.
בי	15. DECEDENT'S EDUCA	ATION	16a. DECEDENT'S	S USUAL OC	CUPATIO	N		18b. KIND OF BUS	INESS/IND	DUSTRY	
COMPLEI	(Specify only highest grade of Elementary/Secondary (0-t2)	College (1-4 or 5+)	(Give kind of life. Do NOT L	work done of use retired.) Home		t of working					
	17. FATHER'S NAME (First, Middle, Lest) Patrick McGra	ath						E (First, Middle, Maiden : nalen	Sumame)		
2	19a. INFORMANT'S NAME (Type/Print) Marguerite U. By	yrne						oute Number, City or Town OCEAN C			21842
	20a. METHOD OF DISPOSITION 1: Burlai 2 Cremation 3 Remote 4 Donation 5 Other (Specify)	val from State	other place)	sition (Na Rayi						City or Tow	
	21. SIGNATURE DE FUNERAL SERVICE LICE	NSEE .				D ADDRESS					
	> Dente	LUNG			Ullr	ich F	une	cal Home	Ber	lin,	Md.
	23. PART 1: Enter the diseases, or co ahock, or haart fellure. L IMMEDIATE CAUSE (Finel disease or condition resulting in death)	list only one ceuse on	asch line.	non				n n GT	ratory ar	rest,	Approximata Interval Batween Onset and Death
	DUE TO (OR AS A CONSEQUENCE OF): EXTREME ARE										
	equantially list conditions, DUE TO (DR AS A CONSEQUENCE OF): Any, lasding to immediate										
3	cause. Entar UNDERLYING CAUSE (Disease or injury		A CONSEQUENCE		4 CC	- LAT		DIGGARE	3-		
CERTIFICATION	that initiated events resulting in death) LAST	DOE TO (ON AS	A CONSECUENCE (orj:							
	PART II Other clasificant conditions	opatellustics to death	but ant accutton	. In the	ala ala da		roes to f	had I am maken		0.05	WERE AUTOPSY FINDINGS
MEDICAL	TANT II. Ottal digitilicant conditions	PERFORMED? 1 YES 2 NO DF D						AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO			
Z Z	25. WAS CASE REFERRED TO MEDICAL						AT. 101				
3	EXAMINER?	HOSPITAL:	tnetlant 3 🗆 DOA	OTHER 4 Num	₹:	ACE OF DE		S Other (Specify)			
PHISICIAN	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TI	_	26c. INJ	7	- I	28d. DESCRIBE HOW II	NJURY OC	CURED	
2	t Natural 5 Pending 2 Accident Investigation	(WOMM, Day, 1661)		М		ES 2	NO				
	3 Suicide 6 Could not be 4 Homicide datarmined	28e. PLACE OF INJUR building, atc. (Sp	RY — A1 home, farm, ecify)	, street, fact	ory, offic			281. LOCATION (Street a City or Town, State)	and Numbe	or or Rural R	oute Number,
COMPLEIED	(Oriock Orin)	CIAN: To the best of my kno									and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER	A	10.00			29c. LICEN	NSE NUM	BER	29d. DA	TE SIONED	(Month, Day, Year)
2	Stophel	Nata	MA	>_		D	27	493		5-45	>-43
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	PEATH (ITEM 27) (Typ	Se, Print)	24/1	AIL	F	DEFAI	1011	7//	1021872
1	MAR 15 1993	32/ REGISTRAR'S SIG	ENATURE - Portable						,		

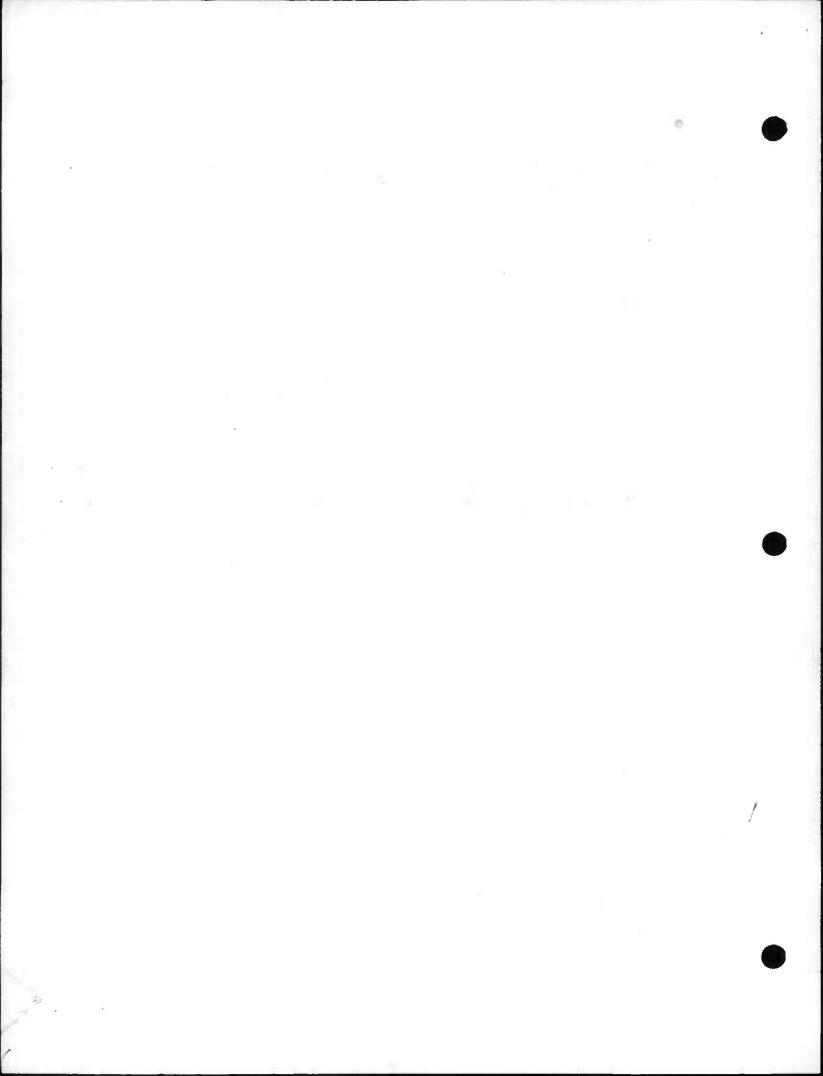


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEDAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be liked within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMENT OF	HEALTH AND M	ENTAL HYGIEN	E	00000	
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH	
	FERNANDO BE				3/8/93	Y YE	6:35 p.M	
	010 00 7750	SEX 6. AGE (In yrs. last 88	The transfer of the state of th				BIRTHPLACE (State or Foreign Country) Md.	
_	9a. FACILITY NAME (If not institution, give street	t and number)	9b. CITY, TOWN	OR LOCATION OF DEAT	OCATION OF DEATH 9c. COUNTY OF DEATH			
TOF.	DEER'S HEAD CENTE	R	SALISI	BURY		WICON	MICO	
DIRECTOR	Md. Worc	ester	POCOMO	rown or location			10d, INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	100. STREET AND NUMBER 2216 Worcester	Rd.		01. ZIP CODE 21851		10g. CITIZEN USA	OF WHAT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 Nover Married 2 Married 3 Widowed 4 Divorced	P. WAS DECEDENT EVER IN U.S. ABM FORCES? 1 YES 2 100 IF YES, GIVE WAR OR DATES	If yes,	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		or No.— 14. I	RACE — American Indian, Black, White etc. Specify: D1 a C K	
	15. DECEDENT'S EDUCATI (Specify only highest grade con		EDENT'S USUAL OCCUPA	TON	16b. KINO OF BUS	INESS/INDUST	RY	
COMPLETED		College (1-4 or 5+)	bo NOT use retired.)	rk done during most of working retired.)			ork	
BE CON	17. FATHER'S NAME (First, Middle, Last)	Isaac Becket	t	18. MOTHER'S NAME Aman	(First, Middle, Meiden :	Sumame)		
TO B	19a. INFORMANT'S NAME (Type/Print) Oliver Purne	11	MAILING ADDRESS (Stree 2216 Wo:	and Number or Aural Rose Cester I	ute Number, City or Town	1, State, Zip Cod 21851	(e)	
	20a, METHOD OF DISPOSITION 1 M Buriel 2 Cremation 3 Removal 4 Donation 5 Other (Specify)		ND DATE OF DISPOSITION (nationy or other place) Johnson		DATE 20c. LOX	CATION — City	or Town, State	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE		AND ADDRESS OF FACE		100	omoke, Mu.	
	· Keith E. U	Tharlow		cton Fune				
	IMMEDIATE CAUSE (Final disease or condition	t only one ceuse on each line,			aa cardiac or respl	ratory arrest,	Approximate Interval Between Onset and Death	
N O	**PNEUMONIA ASPIRATION, UTI **PNEUMONIA AS A CONSEQUENCE OF: **DEMENTIA WITH CONTRACTURES OF ALL EXTREMITIES **DUE TO (OR AS A CONSEQUENCE OF): **DUE TO (OR AS A CONSEQUE							
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury			- STAGE I	I AND III			
ERTI	CAUSE (Disease or Injury that initiated events resulting in desth) LAST c. DECUBITUS ULCERS BOTH HIPS — STAGE II AND III d							
AL C	PART II. Other significent conditions of				art I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS	
	S.P. FEEDING GASTRO	STOMY, ASCVD, I	RENAL INSUF	FICIENCY	PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
MEDIC					_		1 - YES 2 - NO	
ä								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	OTHER:	PLACE OF DEATH (Check				
¥	1 YES NO 1	Inpatient 2 ER/Outpatient 3 28a. DATE OF INJURY	2111	me 5 Residence 6	Other (Specify)	I ILIBY OCCUPE	20	
ВУ Р	XX Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	YES 2 NO	ou. Degoinge How w	WOM COCOME		
8	3 Suicide 6 Could not be detarmined	28e, PLACE OF INJURY — At horr building, etc. (Specify)	ne, farm, street, factory, of	ice 2	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLET		N: To the bast of my knowledge, dear						
	29b. SIGNATURE AND TITLE OF CERTIFIER		- The state of the					
BE	MCHR	ECTUA		29c. LICENSE NUMB	ЕН	29d. DATE SIG	GNED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEATH (ITEM	27) (Type, Print)	D16278		79.1	. 13	
2	M SHDESTHA DEED	S HEAD CENTER 32 REGISTRAR'S SIGNATURE	SALTSRURY	MD. 21801				
31	MAR 12 1993 Turistanian-Randale							

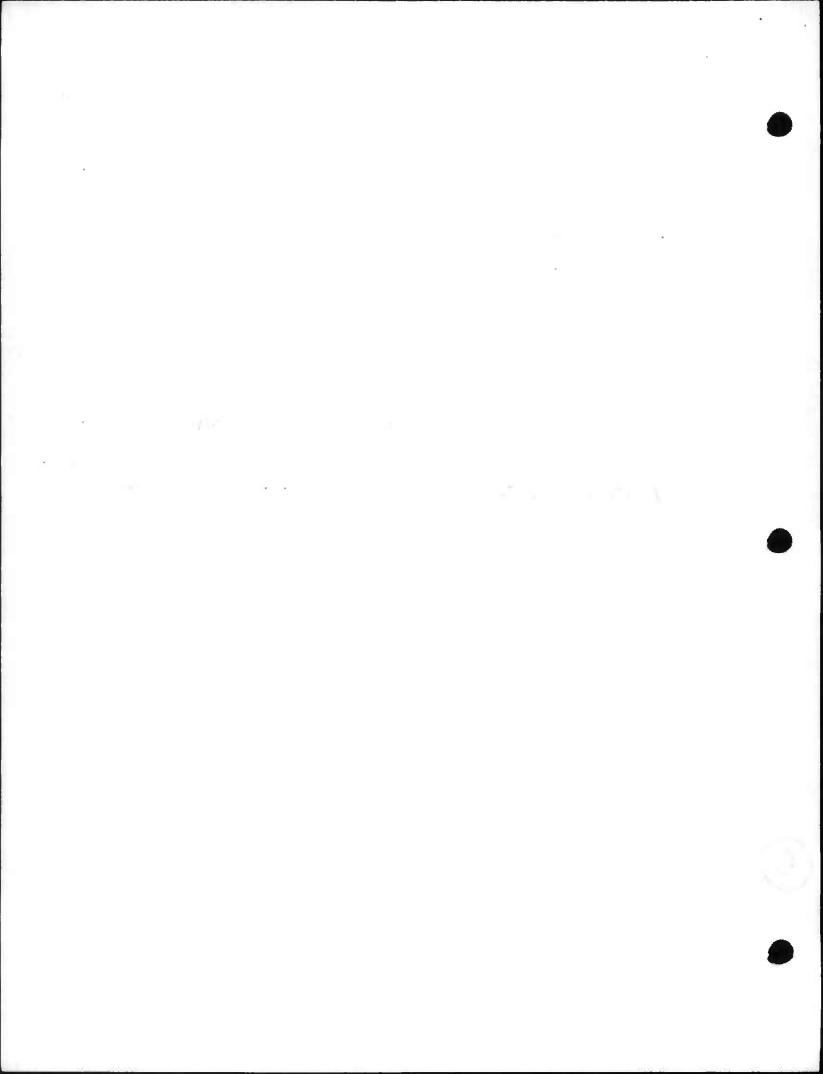


BALTIMORE, MARYLAND 21203-3146 IVISION OF VITAL RECORDS, P.O. BOX 13146,

TO HOSE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 fours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

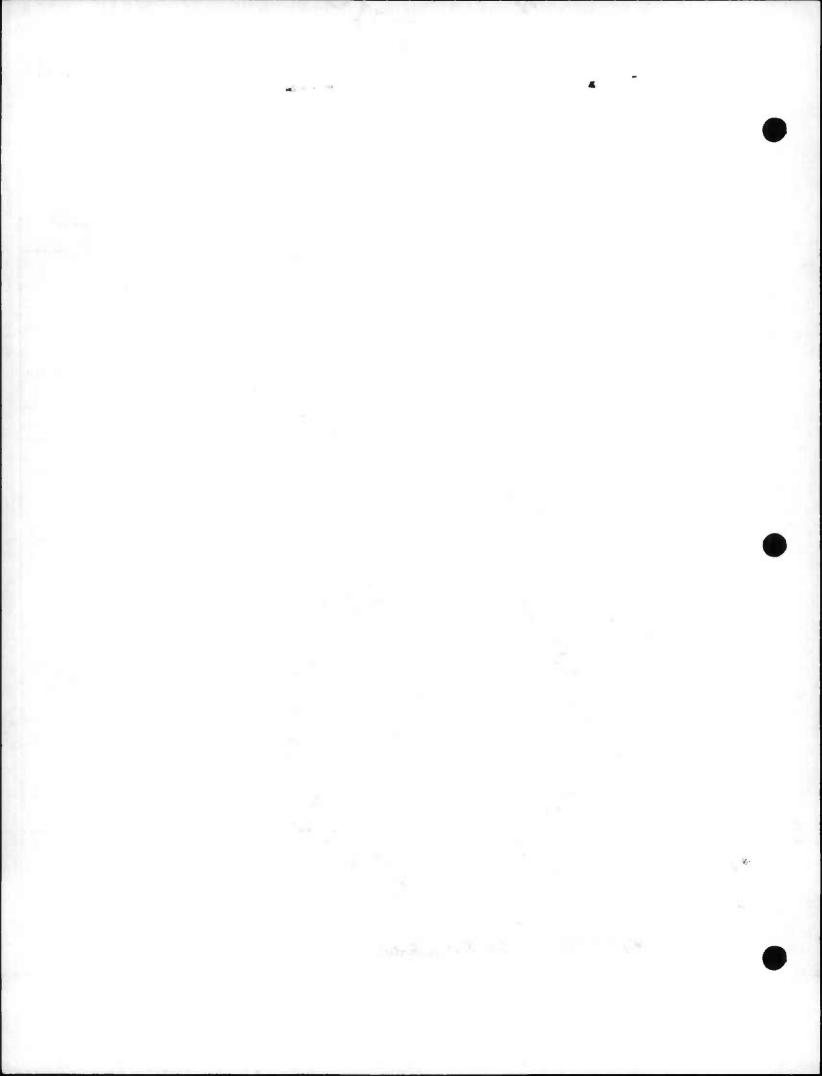
IMPORTANT: Il liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYI			HEALTH AND I	MENTAL HYGIEN REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)	Fleeta	Marie	Burton	1	2. DATE OF DEATH MONTH DATE OF DATE OF DEATH DATE OF DATE OF DATE OF DEATH DATE OF D	Y YEAR	3 TIME OF DEATH A
	153-14-5102	1 □ M 2 🕸	(In yrs. lest birthday) 83 yrs.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 5-27-09	Cou	THPLACE (State or Foreign ntry) Ga •
DIRECTOR	9e. FACILITY NAME (If not institution, give stre RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	et end number)	40° CIT	9b. CITY, TOWN	I OR LOCATION OF OR	ATH	9c. COUNTY OF	10d. INSIDE CITY
		comack	100.017	Tem	perancev	ille	10a CITIZEN O	1 Tyes 2 No
FUNERAL	Rt.	-1 Box 10			23442		L	WHAT COUNTRY?
R	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 NO	It yes,	ecendent of Hispar specify Cuben, Mexice ES 2 NO Specif		BI	CE — American Indien, ack, White, etc. ecity: Black
COMPLEIED	15. OECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)		Ille. Do NOT us	work done during		Hous	e wife	
BE COM	17. FATHER'S NAME (First, Middle, Last)	eorge l	umphrie	S	A	ME (First, Middle, Melden	n	
10 B	196. INFORMANT'S NAME (Type/Print) Bennie Bur	ton	196. MAILING Kt	ADDRESS (STOR	e and Number or Rural	Poute Number, City or Tow Temperan	n, State, Zip Code) C	e,23442
	20e. METHOD OF DISPOSITION 1 Strict Burlel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	ral from State	other place!	rusal	cemetery, crematory or	Tem	cation — city or peranc	eville, Va.
!	≥ 1. SIGNATURE OF FUNERAL SERVICE LICE North €, W			Wha:	and address of facton F. H	Accom	ac, Va	.23301
NO	23. PART i. Enter the diseases, or co shock, or haert failure. Li iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	Due TO (OR AS	lac A CONSEQUENCE O	Ann Mark	est Bleed		Tatory official,	Approximeta interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PRISICIAN: MEDICAL	PART II, Other eignificent conditions	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF I						
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		28 OTHER:	PLACE OF DEATH (C	neck only one)		
2		1 Inpatient 2 SER/Ou		4 🗌 Nursing h	ome 5 Residence		LI III DY OCCUPE	
87 2	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	IN	JURY M 1 [INJURY AT WORK? YES 2 NO	28d. DEŞCRIBE HOW		
ETED	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, firm, street, fectory, office building, etc. (Specify) 28e. Could not be determined 28e. PLACE OF INJURY — At home, firm, street, fectory, office City or Town, State)							al Houte Number,
COMPLETED	onet	IAN: To the best of my kno						se(s) and manner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	1 hlec	1		D3471	MBER 8	29d. DATE SIGN	NED (Morith, Day, Year)
	Jeffred M. Wi	eland M.	560	River	side Dri	ve Suite	101BS	alisbury M
	MAR 12 1993	37. REGISTRAR'S SIG	-Rendall					



ital or attending physician.	completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		
ed by the hos	uld be detache		marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
irs after death. Page 6 may be retained by the r	page 5 short		t be notified
Hage b III	al director,		Iner mus
arter death	y the fune	noval.	cal exam
24 hours	y filled in b	mation, or removal.	the medi
Uted within	I completely	urial, crema	le event,
are De exec	nysician and	prior to bu	r traumat
eam cerunc	tificate has been signed by the attending phy	ntal Hygiene	y, or othe
mar me o	ed by the	th and Mer	any Injur
ne iaw requires in	s been sign	pt. of Heal	3 shows
PHYSICIAN: The I	rtificate has	he State De	or Item 2
ING PHYSIC	After this ce	after death with the State Dept, of Health and Mental Hygiene prior to burial	marked,
JH ALLEND	MRECTOR: A	ours after d	Item 28 Is
HUDFIIAL L	SÜNERAL D	med within 72 ho	PORTANT: If It
# P	THE BE	De Med	IMPOR

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	EALTH AND	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	NORMAN DEI	VT I	BUTLER S	r.		03 10	93	5:05PM w	
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIR	THPLACE (State or Foreign	
	214-18-8785	1 M 2 □ F 87	YRS.	ONTHS DAYS	HOURS MIN.	Mar 17, 19	005 1	Maryland	
~	9a. FACILITY NAME (If not institution, give s		9		R LOCATION OF D	EATH	9c. COUNTY OF		
DIRECTOR	Prince Georges' H	ospital		CHEV	EKLY		PRINCE	GEORGE'S	
EC	10e. STATE 10b. COUNT	Y	10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY	
6	Maryland Princ	nce Georges' Aquasco					LIMITS? 1 X YES 2 NO		
Z Z	10e. STREET AND NUMBER				ZIP CODE			WHAT COUNTRY?	
FUNERAL	23511 Neck Road				20608		USA		
E	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IF FORCES? 1 YES	2 NO			NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No- 14, RA Bit	CE — American Indian, ck, Whita, atc.	
BY	3 X Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES'	1 TYES	2 NO Specif	у:	Sp	Black	
ED	15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. DECEDENT'S US	UAL OCCUPATION)N	16b. KIND OF BU	SINESS/INDUSTRY		
삘	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Labore		st or wonang	F			
COMPLETED	12		Labore	=1		Farmi			
	17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NA	ME (First, Middle, Maiden IOWN	Surname)		
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AI	OORESS (Street a	nd Number or Rurel	Route Number, City or Tow	on State Zin Cordel		
2	Walter Butler				Rd. Aqu		20608		
	20a. METHOD OF DISPOSITION 1 🕞 Burial 2 🗆 Cremation 3 🗀 Rem	20b	PLACE AND DATE OF	DISPOSITION (Na	me al	OATE 20c, LO	CATION — City or	Town, Stata	
	4 Donation 5 Other (Specify)	Št	Philip's	Church	Cem 3/	15/93 Ag	uasco. M	D	
	21. SIGNATURE OF FUNERAL SERVICE LI	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Adams Funeral Home							
	Bloud (stea				o Rd. Aqua	sco MD	20608	
	23. PART I. Enter the diseases, or shock, or haert fallure.	complications that caused List only one cause on e	the death. Do not	anter tha mo	de of dying, suc	h as cardiac or resp	iratory arrest,	Approximate Interval Between	
	IMMEDIATE CAUSE (Final								
	disease or condition resulting in death)	s. Seps w							
	DUE TO (OR AS A CONSEQUENCE OF): Multiple Decembers when								
NO.	Sequentially list conditions, OUF TO (OR AS A CONSCIUENCE OF).								
S	cause. Enter UNDERLYING								
트									
CERTIFICATION	Todaling in dodling Exten	resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): a. Multiple Curebiouse wish Accounts							
AL	PART II. Other significent condition	s contributing to deeth b	ut not resulting in	the underlying	ceuse given in	Part I. 24s. WAS AN		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
MEDIC	Multi-interes	charcter				1 _ YES 2	- 40	COMPLETION OF CAUSE OF DEATH?	
ME	Confection					_		1 _ YES 2 _ NO	
Ä.									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		THER:	ACE OF OEATH (CI		-		
HYS	1 YES 2 - NO	1 Inputient 2 ER/Outp	28b, TIME (6 Other (Specify) 28d. OESCRIBE HOW I	N.IIJBY OCCURED		
	14 Natural 5 Pending	(Month, Day, Year)	INJUR	Y WO	RK? 'ES 2 NO				
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28s. PLACE OF INJURY building, etc. (Spec	— At home, farm, atre	et, factory, office		261. LOCATION (Street		Route Number,	
TE	4 Homicide determined	Salaring, star topica	~· <i>y</i> /			City or Town, State)			
COMPLETED	29a. CERTIFIER (Check only	ICIAN: To the beat of my know	ledge, death occurred	at the time, data	and place, and due	to the cause(a) and ma	nner as stated.		
Š	2 MEDICAL EXAMINE	ER: On the basis of examination	n end/or investigation,	in my opinion, d	eath occured at the	time, date and place, ar	nd due to the cause	(e) and menner ee stated.	
BE (296. SIGNATURE AND TITLE OF CERTIFIE	R	ad thy	11110-	29c. LICENSE NU	MBER	29d. DATE SIGNI	Month, Day, Year)	
5	20 NAME AND ADDRESS OF THE	10 00000	7. /		2210	1.1	> 3/11	113	
	30. NAME AND ADORESS OF PERSON WITH DON H. YABLOND	WITC, MO 10	TOU Gree	2 p < 17	kd. 711	31 Séctio	ok, mo	20704	
	31. DATE FILE MAR 177 93	32. REGISTRAR'S SIGN	ATURE Randelle						



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a feath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
TRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTA			MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)				2 DATE OF DEATH			
	Carl Bla	ine BENSON				March 16	, 1993 YEA	4:05 p.m
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In	yrs. last birthday) IF	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. Bit	RTHPLACE (State or Foreign
	230 12 2770	X M 2 □ F	81 YRS.	NTHS DAYS	HOURS MIN.	July 14,	1911 W	est Virginia
.	9a. FACILITY NAME (If not institution, give street		91		R LOCATION OF DE	EATH	9c. COUNTY O	F DEATH
DIRECTOR	Cuppett-Weeks Nursi	ing Home		0ak	land		Garı	rett
Ä	10a. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCAT	ON			10d. INSIDE CITY
	West Virginia Gra	ant	nt Bay					1 ☐ YES 2 🔀 NO
FUNERAL	10e. STREET AND NUMBER		101. 211				10g. CITIZEN C	F WHAT COUNTRY?
ᇤᅵ	Rt. 1 Box 37				26707		USA	1
5		. WAS DECEDENT EVER IN FORCES? 1 X YES				IIC ORIGIN? (Specify Yen, Puarto Rican, atc.)	s or No— 14. R	ACE — American Indian, lack, White, etc.
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DAT			2 NO Specify			pecify:
		WWII						White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade com	ppleted)	18a. DECEDENT'S US (Give kind of work life. Do NOT use re	done during mos	N t of working	16b. KIND OF BU	JSINESS/INDUSTR	Y
ן ב	Elementary/Secondary (0-12) C	ollege (1-4 or 5+)	Sawyer	N. 100.7		S a	w Mill	
\$	17. FATHER'S NAME (First, Middle, Last)		Sawyer		16 MOTHERIO NA	ME (First, Middle, Malde		
	Robert C.	Por	nson				_	V1
H	19a, INFORMANT'S NAME (Type/Print)	Бег		DBECC (Street o	Mary	Pea Route Number, City or To		Everly
임	Mae B. Benson					l, West Vi		
ŀ	20a. METHOD OF DISPOSITION	206.	PLACE OF DISPOSITI				OCATION - City o	
	1 XBurial 2 Cremation 3 Removal 4 Donetion 5 Other (Specify)	from State	ayard Cen		otory, oremetory or			West Virginia
	21. SIGNATURE OF FUNERAL SERVICE LICENS				D ADDRESS OF FA			
	D. F. 10. 7/	1-			t Funer			01550
	23. PART I. Enter the diseases, or com	usler.	Ab death Death					, MD 21550
Z	ahock, or heert failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death) s	only one cause on ee	ch line.			calar o		Interval Between
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PHYSICIAN: MEDICAL	PART II. Other aignificant conditions of	ontributing to deeth bu	it not resulting in (the underlying	csuse given in		RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO
N N	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				ACE OF DEATH (Ch	eck only one)		
S		OSPITAL: ☐ Inpetient 2 ☐ ER/Outpe	tient 3 DOA 4	THEB:	5 - Residence	6 Other (Specify)		
Ē	27. MANNER OF OEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME C			28d. DESCRIBE HOW	INJURY OCCURE	
BY	1 Netural 5 Pending 2 Accident Investigation			M 1 🗆 Y				
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Special	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rura: City or Town, State)					ral Route Number,
3 Suicide 4 Homicide 5 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL Families on the balls of examination and/or investigation, in my opinion, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. Signature Ano Title of Certifier 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, M.						se(a) and manner as stated.		
) BE	/ / W	Mr M			030	035	1 3/	16/93
2	30. NAME AND ADDRESS OF PERSON WHO CO	an official many factors are	th (ITEM 27) (Type, Prind-Deer P		d Oakle	and, Maryl	and 215	50
	Dr. Donald Richter 31. DATE FILED (Month_Day, Year)	32. BEGISTRAR'S SIGNA	TURE	ark Nuc	u Jakla	ind, Haryr	Z 1 J	
3	31. DATE FILED (Month, Day, Year) MAR 1 9 1993	Julia Davidson	~ Randalle					

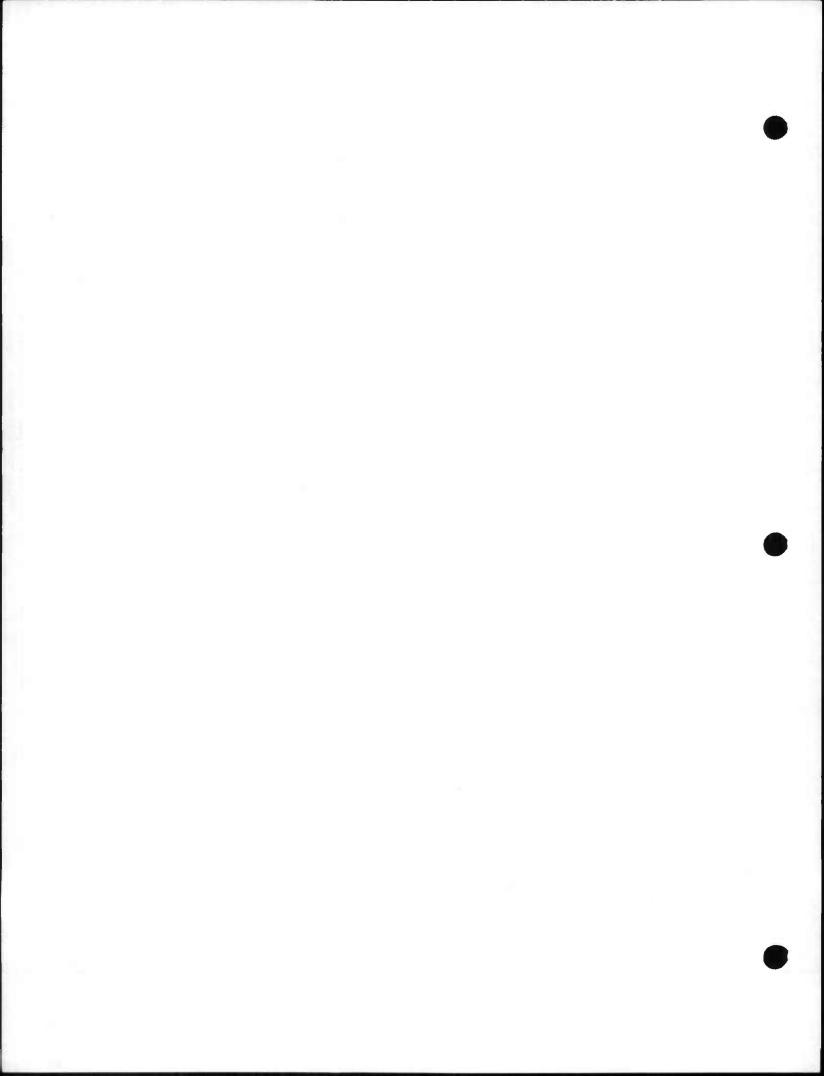
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OSPING OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE PART OF THE PART HAS BEEN SQUIRED by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be contact that the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

WILL Filler 28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	HEGISTHAR			CHIIF	ICALE	: UF	DEA	П	REG. N	10.		
	1. DECEDENT'S NAME (First, Middle, Lest)								2. DATE OF DEATH MONTH	DAY	YEAR	3. TIME OF DEATH
	JEAN B. CONWAY									ARCH 13, 1993 10:30 A M		
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. in	ast birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTI Count	HPLACE (State or Foreign
	208-16-6871	1 🗆 M 2 📈 F	68	YRS.	WORTHS.	DATS	HOURS		FEB. 9,			NSYLVANIA
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY,	TOWN (OR LOCATION			7	UNTY OF	DEATH
DIRECTOR	5210 LOCUST AVE	NUE				BE	THESE	λ		4	моито	GOMERY
5	RESIDENCE OF DECEDENT										110111	JOHERT
	10a. STATE 10b. COUNT	TY .		10c. CIT	Y, TOWN O	R LOCAT	TION					10d, INSIDE CITY LIMITS?
	MARYLAND MO	NTGOMERY		E	BETHE	SDA						1 YES 2 X NO
FUNERAL	10e. STREET AND NUMBER					101	. ZIP CODE	E		10g. CI	TIZEN OF	WHAT COUNTRY?
ᇤ	5210 LOCUST AV	ENUE					208	314		UN	TTED	STATES
3	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S.	RMED	13. \	MAS DEC	ENDENT C	F HISPAN	IC ORIGIN? (Specify	Yes or No-	14. RAC	E - American Indian.
	1 Never Married 2 1 Married	FORCES? 1		NO			ecify Cuba 2 K NO		, Puerto Rican, etc.)		Spec	k, White, etc.
BY	3 Widowed 4 Divorced						- 22	.,			1	WHITE
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad		16a. D	ECEDENT'S	USUAL OC	CUPATIO	ON .		18b. KIND OF	BUSINESS/II	NDUSTRY	
띹	Elementary/Secondary (0-12)	College (1-4 or 5+	À	Give kind of the Do NOT ut	ne retired.)	Juning Inio	IST OF WORK					
E		2		HOME	IAKER				OWN	HOME		
0	17. FATHER'S NAME (First, Middle, Last)					_	18. MOTI	HER'S NAM	ME (First, Middle, Maid	en Sumame)		
BE C	MICHAEL	BRADSHAW						BERT	יד באי	OMBEK		
	19a. INFORMANT'S NAME (Type/Print)		1	9b. MAJLING	ADDRESS	(Street a	nd Number		loute Number, City or			
입	NEAL J. CONWAY,	SR							THESDA,			20814
			_	EANDDATE				, DE		LOCATION -		
	20a METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rer 4 Donation 5 Other (Specify)	noval from State	cometen c	remetory or o	ther place!			D 37 2	1		•	•
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE										G, MARYLAND
	ROBERT A. PUMPHREY FUNERAL HOME/											
	AVENUE, BETHESDA, MARYLAND 20814-3501											
	23. PART I. Enter the diseases or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heert failure. List only one cause on each line.											
	IMMEDIATE CAUSE (Fine)	List only one caus	e on each lin	16.								Interval Between Onset and Death
	disease or condition MVCC2 PD 121 TNP2 PC///TOV							Arms				
1	resulting in death) Due TO (OR AS A CONSEQUENCE OF):											
7								101000				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate		OR AS A CONSI			TOVE	эрсоп	INIC D	IDEADE			INDEF
8	cause. Enter UNDERLYING	CHRONI	C OBST	RUCTI	VE P	III.M <i>C</i>	MARY	DIS	EASE			11100F
Ĕ	CAUSE (Disease or injury that initiated events CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO (OR AS A CONSEQUENCE OF):											
ᇤ	resulting in death) LAST											
2	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS											
DICAL	PART II. Other algoriticant condition	na contributing to	leath but not	resuiting	in the un	derlying	g cause g	given in i		AN AUTOPSY ORMED?	7 24b	MAILABLE PRIOR TO
음										2 🔯 NO		COMPLETION OF CAUSE OF DEATH?
ME											1	1 YES 2 NO
, ,									_			
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL					26. PL	ACE OF D	EATH (Che	ck only one)			
Sic	EXAMINER? 1 X YES 2 NO	HOSPITAL:	ER/Outpatient	3 🗍 DOA	OTHER		- s 1/1 e-	aldaman (8 Other (Specify)			
¥	27. MANNER OF DEATH	26e, DATE OF I	NJURY	28b. TIM	_	28c. INJ		/ /	28d. DESCRIBE HO	V INJURY O	CCURED	
	1 Netural 5 Pending	(Month, Da	(, Year)	IN	URY M	WO	RIC? YES 2	2/40	6	1	1	
BY	2 Accident investigation 3 Suicide 6 Could get be	28e. PLACE OF	INJURY — At h	ome, farm,	treet, facto			-	281. LOCATION (Stre	C BU	The Burney	DO 1
	3 Suicide 6 Could not be 4 Homicide determined	building, a	tc. (Specify)	411	11		10		City or Town, Sta	to)	ar or noral	riodie Number,
COMPLET	29a. CERTIFIER		17	110	NO	V	W			2 141		
AP	(Check only CENTIFTING PHTS	ICIAN: To the best of r										
Ö	2.6. MEDICAL EXAMIN	ER: On the beats of ax	imination and/or	r investigatio	n, in my o	pinion, d	eath occur	ed at the t	ime, data and place,	and due to	the cause(a) and manner as stated.
w I	286. SIGNATURE AND FITLE OF CERTIFIE	R VIII.	100		9		29c. LICE	NSE NUM	BER	29d. D/	TE SIGNED	(Month, Day, Year)
B	Alle Comment	Duna	41	//	1	,	מת	07099)	•	MARC	н 15, 1993
2	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED LAUS	OF DEATH (IT	EM 27) (Type,	Print)		D	.,			MIC	1 10, 1993
	FRANCIS MAYLE, M.	D. 10215	FERNW	OOD R	OAD.	ВЕТ	HESD	Д. М	ARYLAND	2081	7	1
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR	'S SIGNATURE		_	لاندن	עטעייי	-19 Pl	TIVITUID	FOOT	,	
	MAR 16 '93		widson	ande 82								
	1 T T T T T T T T T T T T T T T T T T T											

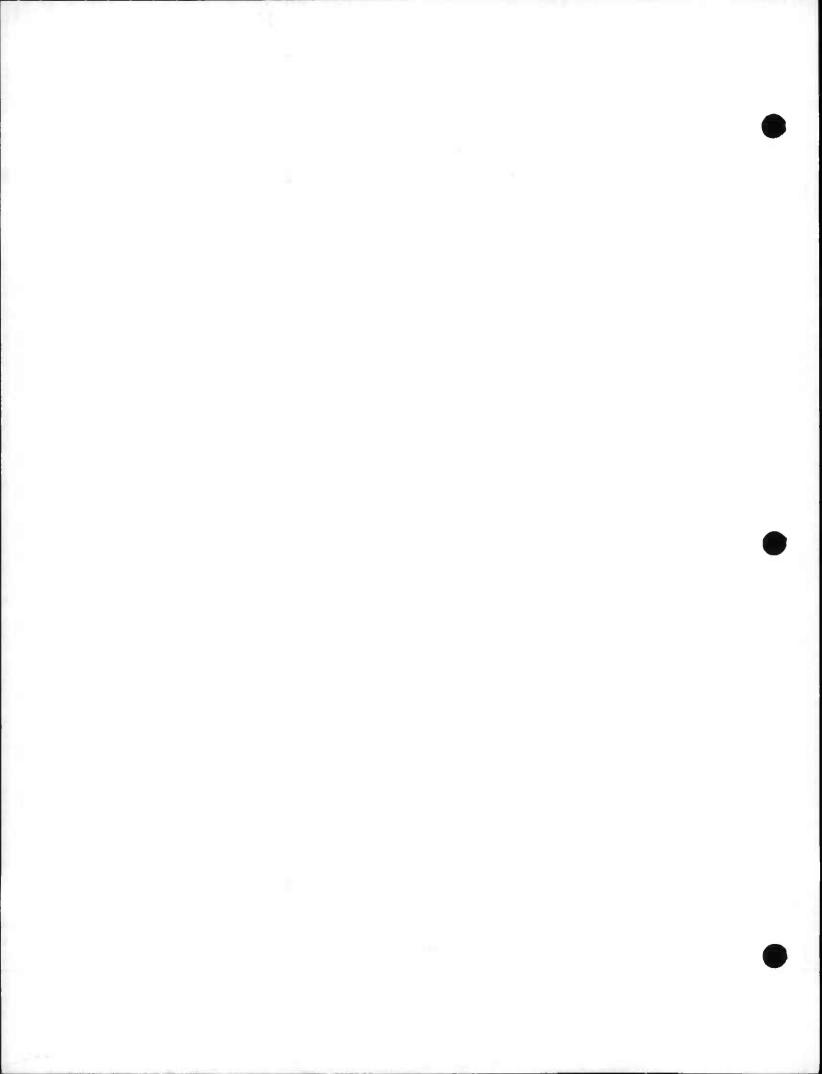


BALTIMORE, MARYLAND 21215-0020	SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	or removal.	medical examiner must be notified at once.	
DIMISION OF VILAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 in	TO THE PURE METAL DIFFERENCE After this certificate has been signed by the attending physician and completely fills	we may write a four the state Uept. Of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT IT TISM 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

0434750	BENNER,	CHARLES N	
2-27-93	展集会人	4101	
Mark con		3-27-00	0870

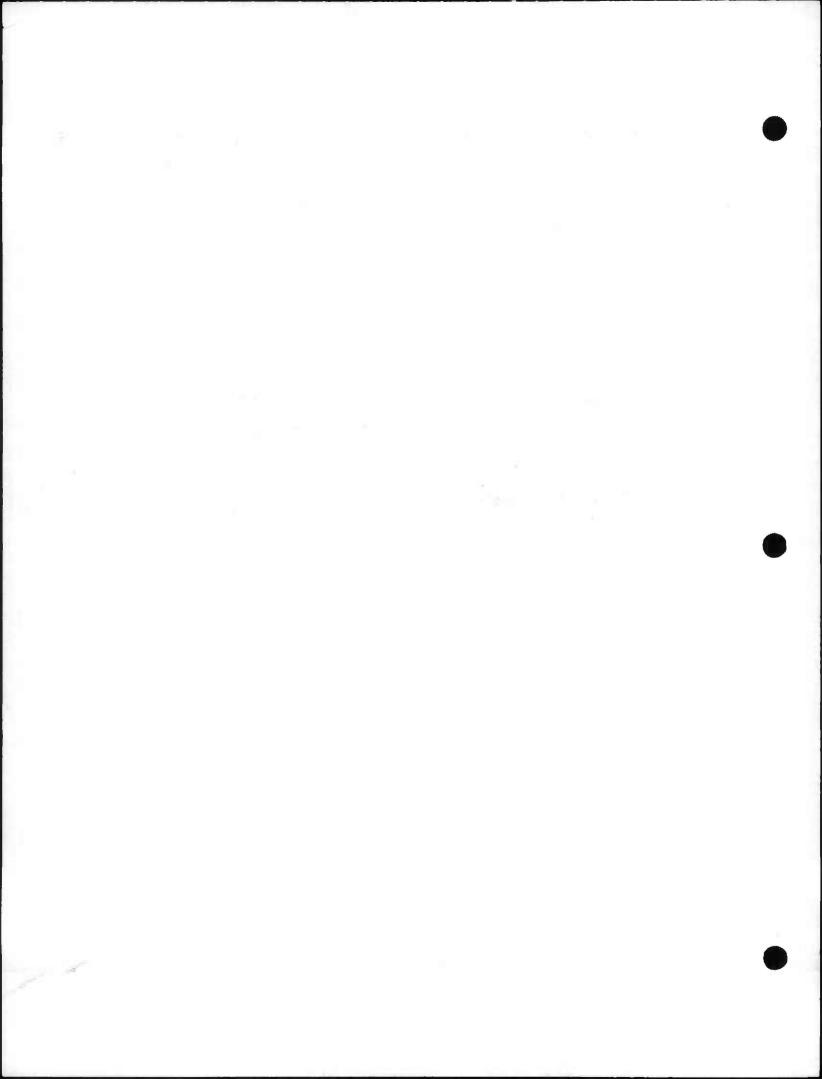
4 U.S.	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
TRAR	CERTIFICATE OF BEATU	REG. NO.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEAD CERTIFICATE OF DE		TAL HYGIENE REG. NO.	50				
	1. DECEDENT'S NAME (First, Middle, Last)		ATE OF DEATH		3. TIME OF DEATH	_		
	MARY CALVANO	MC MC	NITH DAY	YEAR 93	1100 P	M		
	A COUNTY OF THE PARTY OF THE PA		TE OF BIRTH		THPLACE (State or Foreign			
	212-74-3787 1 M 2 T F 86 YRS. MONTHS DAYS HOW		lonth, Day, Year)	Cour	ntry)			
	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LO		RCH 27,19	9c. COUNTY OF	ALY			
DIRECTOR	WASHINGTON ADVENTIST HOSPITAL TAKOMA P			ONTGOM				
E C	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY	_		
P	MARYLAND PRINCE GEORGE'S MT. RAINIER				LIMITS?			
	100. STREET AND NUMBER 101. ZIP	CODE		Ma CITIZEN OF	WHAT COUNTRY?	_		
H	4704 25TH STREET 2	0712	1	USA				
FUNERAL		ENT OF HISPANIC OR	IOINO REIV. W		NE 4-14	_		
	1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify	Cuban, Mexican, Puer		Bia	CE — American Indian, ck, White, etc.			
BY	3 🖔 Wildowed 4 🗆 Divorced IF YES, GIVE WAR OR DATES 1 🗆 YES 2 📡	NO Specify:			c#y: VHITE			
0	15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION		16b. KIND OF BUSIN		AILTIE	-		
ET	(Specify only highest grade completed) (Give kind of work done during most of a life. Do NOT use retired.) (Give kind of work done during most of a life. Do NOT use retired.)	working	100. 1010 01 00011	COOMINGOOTH				
PL	12 HOUSEWIFE							
COMPLETED		MOTHER'S NAME (Fir	an Addition Mariates Co.			-		
	DATE TO SECOND S			mame)				
BE			VANO					
70	133 113 133 133 133 133 133 133 133 133							
	MARIO L. CALVANO (SON) 10191 VALENTINO		AKTON, V					
	20a. METHOD OF DISPOSITION 1 Note: The image of the imag			TION — City or 1				
Ī	4 Donetion 6 Other (Specify) GATE OF HEAVEN CEME			R SPRIM	IG, MARYLAND]		
	21. SIGNATURE OF FUNEBAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC.							
_	11 1 11 11 11 11 11 11 11 11 11 11 11 1			-	,MD.20901			
	23. PART I. Enter the diseases, or corpolications that caused the death. Do not enter the mode of	f dying, such as c	ardiac or respirat	lory arrest,	Approximate	\neg		
- 1	anock, or heart failure Clat only one cause on each line.				Interval Between Onset and Dea			
	IMMEDIATE CAUSE (Final disease or condition Presulting in death) CANGEST VEHEART FAILURE							
	resulting in death) DUE TO (OR AS A CONSEQUENCE OF):	,,				\dashv		
_	- ADRTIC STENOSIS				i			
6	Sequentially list conditions,							
A	If any, leading to immediate cause. Enter UNDERLYING				į			
윤	CAUSE (Disease or Injury C.							
E	that initiated events out to (or as a consequence of): resulting in death) LAST							
CERTIFICATION	d				-	\dashv		
AL	PART ii. Other significant conditions contributing to death but not resulting in the underlying cou	use given in Part I			b. WERE AUTOPSY FINDING	is		
5			PERFORME		AMAILABLE PRIOR TO COMPLETION OF CAUSE			
			1 🗌 YES 2 🗍	, NO	OF DEATH?	- 1		
2			1		1 Nes 2 No	Н		
A	25. WAS CASE REFERRED TO MEDICAL 26 PLACE	OF DEATH (Charle and				-		
PHYSICIAN: MEDIC	EXAMINER? HOSPITAL: OTHER:	OF DEATH (Check only				\dashv		
≥	1							
ᆲ	1 Metural 5 Panding (Month, Day, Year) INJURY WORK?		DESCRIBE HOW INJU	URY OCCURED				
B	Z Accident Investigation 1 YES	2 NO						
	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)		OCATION (Street and lity or Town, State)	Number or Rural	Route Number,			
Ë l	4 Homicide determined							
COMPLETED	29s. CERTIFIER (Check only) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and p	place, and due to the	cause(s) and manne	r as stated.		\neg		
<u> </u>	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death of				(e) and manner as stated.			
	as against the property of the					4		
BE	1/// // //	D 3 / 56		9d. DATE SIGNE	D (Month, Day, Year)			
ဥ	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	7 21 20	/) -	1777			
	CHARLES BENNER MD 1161 N.H. AVE,	SILVE	K SPRIN	IS MC	20904			
	31. DATE FILED MONTE Day Mary 33. PROJETRATE SIGNATURE SUMMER DAVID STORE DE L'ANGUER DE L							



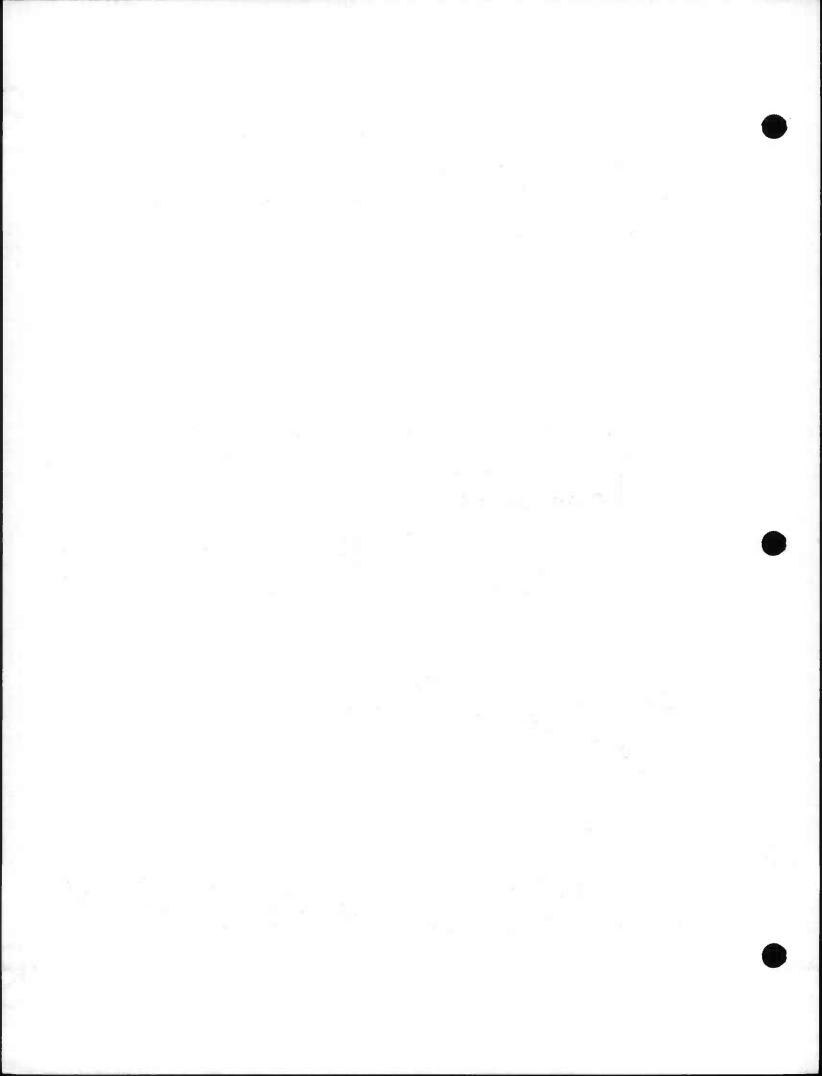
BALTIMORE, MARYLAND 21215-0020	's after death. Page 6 may be retained by the hospital or attending physician.	TOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	dical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be intained by the hospital or attending physician.	TO THE AUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filled within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - STATE REGISTRAR	STATE OF MARY		MENT OF HEA CATE OF DI		ENTAL HYGIEN REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF OEATH
		J. Chakalaki	S			3 II	" 9	3 901 P 1
	4. SOCIAL SECURITY NUMBER				UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
	279-03-3864	1 X M 2 □ F	/ / YRS.		5.07		15	Wash, DC
œ	98. FACILITY NAME (If not institution, give Holy Cross Hospi		1	9b. CITY, TOWN OR LO		гн	9c. COUNTY	A. C. C. C. C.
16	RESIDENCE OF DECEDENT	tai		Silver S	pring		Montg	omery
DIRECTOR	10e. STATE 10b. COUNT		10c. CITY,	TOWN OR LOCATION				10d. INSIDE CITY LIMITS?
		tgomery	Si	lver Spri	0			1 X YES 2 NO
FUNERAL	100. STREET AND NUMBER 12826 Teaberry R	1		10t, ZIP				OF WHAT COUNTRY?
N N	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN ILE ADMED		0906			USA
	1 Never Merried 2 Merried	FORCES? 1 A YES	2 NO		Cuben, Maxicen,	ORIGIN? (Specify Yes Puerto Ricen, etc.)	or No 14.	RACE American Indian, Black, White, etc.
ВУ	3 Widowed 4 Divorced	1943-19		1 1 1E3 2 E	Specify:			Specify: White
별	15. DECEDENT'S EDI (Specify only highest grad	JCATION le completed)	18a. DECEDENT'S US (Give kind of wo	rk done during most of	working	16b. KINO OF BUS	INESS/INDUS	
Ž.	Elementary/Secondary (0-12)	College (1-4 or 5+)	file. Do NOT use	ontractor				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Sales Co		MOTHER'S MANY	Constri		
E C	James K. Chakala	kis		10.		lacokefalo		
00	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	ODRESS (Street and No		ute Number, City or Town		de)
2	Cerelle Chakalak	is	12826 1	Teaberry I	Road Si	lver Spri	ng, MD	20906
	20s. METHOD OF DISPOSITION 1-1 Burlel 2 Cremetion 3 Ren	noval from State	b. PLACE AND DATE OF	DISPOSITION (Name of			ATION — City	or Town, State
	4 Donation S Dotter (Specify)	A	Glenwood				ningto	n, D.C.
	21. SIGNATURE OF YOMERAL VERVICE E	11. 11-		Hines-Ri		.m Funeral Ho	ome	20904
	Muly N	Kurwar		11800 Ne	ew Hamps	shire Ave.	Silv	er Spring, MD.
	23. PART I. Enter the diseases, or shock, or heart failure.	complications that cause List only one cause on a	d the death. Do not each line.	t enter the mode o	of dying, such	as cerdiec or respi	ratory errest	, Approximate interval Between
	iMMEDIATE CAUSE (Finel disease or condition	٨. ،	0 -					Onset and Death
	resulting in death)	a. OUE TO COR AS	A CONSEQUENCE OF):					
-				lead.	[, 0,	0		
ᅙ	Sequentially list conditions,							
ا سرا	cause. Enter UNDERLYING							
2		a Ather	oschorati	i bea	J 0	lisease		
TIFICA	cause. Enter UNDERLYING	a Ather	Α	i bea	+ 0	Usearl		
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	c. Ather DUE TO (OR AS .	a consequence of):	i bea	J 0	Useasl		
귤	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	c. Ather DUE TO (OR AS .	a consequence of):	the undarlying car	use given in Pa	acara.		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
귤	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	c. Ather DUE TO (OR AS .	a consequence of):	the undarlying car	use given in Pa	ert I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	c. Ather DUE TO (OR AS .	a consequence of):	the undarlying car	use given in Pa	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that inklated events resulting in death) LAST PART II. Other significent condition	c. Ather DUE TO (OR AS .	a consequence of):			PERFOR 1 TYES 2	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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ED BY PHYSICIAN: MEDICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) CERTIFYING PHYS	DUE TO (OR AS d	Dut not rasulting in patient 3 DOA 4	26. PLACE DTHER: I Nursing Home 5 OF 28c. INJURY WORK? I YES eet, factory, office at the time, data end	OF DEATH (Check Rasidence 6 AT 2 NO 2	PERFOR 1 YES 2 Conly one) Other (Specify) 8d. OESCRIBE HOW IP 8t. LOCATION (Street a City or Town, State)	MED? NO NO NO NO NUMBER OF I	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Rural Route Number,
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle 2. DATE OF DEATH 3. TIME OF DEATH Clemmer Helen 912 03 10:10 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 1 - M 2 F 578-28-3328 AUG. 27, 19 WASHINGTON, D.C. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH IRECTOR Holu 207 SILVER SPRING MONTGOMERY RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY MARYLAND MONTGOMERY Ճ SILVER SPRING permit. 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? director, page 5 should be detached for use as the burial-transit 3406 RANDOLPH ROAD 20902 Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuban, Mexican, Puarto Rican, etc.)
 U YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 XNO 1 Never Married 2 Married ΒY 3 🕅 Widowed 4 🗌 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Specify only highest grade comp. Elementary/Secondary (0-12) College (1-4 or 5+) COUNTY GOVERNMENT CROSSING GUARD 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) F EDGAR ADAM POORE BE BESSIE THERESA COOKE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 CLEMMER. 24100 BUSH HILL ROAD GATTHERSBURG. 20882 MD be METHOD OF DISPOSITION Burlet 2. Cremetton 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must GATE OF HEAVEN CEMETERY SILVER SPRING, MARYLAND examiner 22. NAME AND ADDRESS OF FACILITY filled in by the funeral ion, or removal. executed within 24 hours after death. FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., WEST SIL.SPR medical 23. PART I. Enter the diseases, or complication that caused the death. Do not antar the mode of dying, such se cardiac or respiratory errest, Approximata ahock, or haart failure. List only Dna cause on each line. Intarvai Between Onset and Death l completely filled irial, cremation, c **IMMEDIATE CAUSE (Final** the disease pr condition resulting in death) traumatic event, prior to burial, necus CERTIFICATION and Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediata cause. Enter UNDERLYING attending physician ntal Hygiene prior to certificate be cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated evants resulting in death) LAST ò the death has been signed by the atter Dept. of Health and Mental injury, PART II gthar significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMED? that 1 TYES 2 NO shows OF DEATH? 1 TES 2 NO PHYSICIAN: ₩. 23 25. WAS CASE REFERE 26. PLACE OF DEATH (Check only one The Nem State 1 YES 2 NO this certificate HOSPITAL: OTHER: M. OR ATTENDING PHYSICIAN: 1 Inpetient 2 II ER/Outpetient 3 II DOA ne 5 🗌 Residence 4 🖂 Other (Specify) the 6 27. MANNES OF BEATH 28s. DATE OF INJURY (Month, Day, Year) 25c. INJURY AT WORK? marked, 26b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED with Natural 1 YES 2 NO death BY DIRECTOR: After 2 Accident 25e. PLACE OF INJUSTY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 60 281. LOCATION (Street and Number or Rural Route Number City or Town, State) Could not be BE COMPLETED after 4 Homicide IMPORTANT: If Item 28 determined n 72 hours a 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(e) end manner ee stated. MEDICAL EXAMINER: On the basis of examinati red at the time, data and pieca, and dua to the cause(a) and menner as stated. 2



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IL RECORDS, P.O. BOX 68760,	moquires that the death certificate be executed within 24 nours after death. Pa
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SIGNATINE are requires that the death certificate be executed within 24 fours after death. Page 6 may be retained by the hospital or attending physician. Commissioned by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the Same Deut of Health and Mental Hygiene prior to burial, cremation, or removal. Same Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR	9a. FACILITY Shad RESIDEN 10a. STATE MD 10a. STATE 124 11. MARITAL 1
the fune wal.		>
TO THE MOSTALL OF CHENDING PROSICIAN. The seminatives that the death certificate be executed within 24 flours after death. Page 6 may be retained by the hospital or attending physician. TO THE MARKET DIRECTOR ARE THE CENTRAL AND THE MOSTAL AND THE MARKET AND THE MOSTAL AND TH	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	23. PART IMMEDIAT disease of resulting Sequential if any, lest cause. Er CAUSE (C) that initial resulting PART II. (2) 25. WAS CA EXAMIN- 1 YE 27. MANNET 1 Net 2 Ac 3 Su 4 Ho 298. CERTIII (Check One) 30. NAME A

4. SOCIAL 209

FOR STATE REGISTRAR		STATE OF I	MARYL					EALTH AND I	MENT	TAL HYGIENI REG. NO.	9	3	08707
1. DECEDENT'S NAME (First,	Middle, Last)								2. D/	TE OF DEATH	v -	YEAR	3. TIME OF DEATH
Roberta		J.		CAR	LSON					rch 17			6:27 A. M
4. SOCIAL SECURITY NUME	ER	5. SEX	6. AGE ('in yrs. las	t birthday)	IF UNDER 1	YEAR DAYS	IF UNDER 24 HRS.	7. DA	TE OF BIRTH onth, Day, Year)		8. BIRTI Count	HPLACE (State or Foreign
209-07-631	-	1 M 2 F		74	YRS.	montins	DATS	HOURS MIN.		-18-1918			PA.
9a. FACILITY NAME (If not in	stitution, give a	street and number)				9b. CITY,	TOWN (OR LOCATION OF DE	HTA		9c. COU	NTY OF C	DEATH
Shady Grove		ntist Hos	spita	a1		Rock	vil	le			Mon	tgom	ery
10e. STATE	10b. COUNT	Y			10c. CITY	, TOWN OF	LOCAT	TION					10d. INSIDE CITY LIMITS?
MD.	Mon	tgomery			Ga	aithe	rsb	urg					1 TYES 2 NO
10e. STREET AND NUMBER							101	. ZIP CODE			10g. CIT	IZEN OF	WHAT COUNTRY?
124 Windl	orooke	Circle						20879				U.S.	Α.
11. MARITAL STATUS	AC-CA	12. WAS DECEOEN FORCES? 1	T EVER II	N U.S. AR	MEO	13. W	AS OEC	ENDENT OF HISPAN	NIC OR	GIN? (Specify Yea	or No-	14. RAC	E — American Indian, k, White, atc.
1 Never Merried 2 3 Widowed 4 Divo		IF YES, GIVE V	WAR OR D	ATES				2 NO Specifi		to ricari, atc.)		Spec	The second second
15. DEC	EDENT'S EDU	ICATION Completed		16a. OE	CEDENT'S	USUAL OC	CUPATIO	ON at of working	T	18b. KIND OF BUS	INESS/IN	DUSTRY	
Elemantary/Secondary (C		College (1-4 or 5	+)	life.	Do NOT us	e retired.)	inng mo	at or worlding					
12					Bookk	eepe:	r			Coin Ex	chan	ge C	lo.
17. FATHER'S NAME (First, M	liddle, Last)							18. MOTHER'S NA	ME (Fir	st, Middle, Maiden	Sumame)	V = 1	
Han	rry D	orman							E	Edith M	omey	er	
19a. INFORMANT'S NAME (1	Type/Print)			19	b. MAILING	ADDRESS	(Street a	and Number or Rural	Route N	lumber, City or Town	n, State, Zi	p Code)	
Judy Wat	ts			2	0349	Bick	1et	on Place	, (Saithers	burg	, MD	20879
20a. METHOO OF DISPOSIT 1½ Burlal 2 - Crematic	n 3 🗆 Rem	noval from State	of	cemetary	AND DATE	or other pla	ice)		1				own, State
4 Donetion 8 Other		CENCEE	_ [Pa	irkla	awn M			Park		/19 Ro	CKV1.	lle,	MD.
▶ W	L SERVICE LI	O A C	il	l-m	_					DeVol			Home g, MD. 20877
23. PART I. Enter the d	iseases, or	complications the	at cause	d the de	eth. Do n	_							Approximate
shock, or h		List only one cer	use on e	ech line									Interval Between Onset and Death
disease or condition resulting in death)	101	HEN	106	PRI	1AC	10		TROK	F				/ MONTH
resulting in death)	13.	DUE TO	(OR AS	CONSE	OUENCE OF	7:							7-1-1-1-1-1
Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Inju	diate ING				OUENCE OF								
that initiated events resulting in deeth) LAS		d. ADVA	(OR AS	E L	OUENCE OF	EU	76	CAR	01	Nom	A		6 MONTHS
PART II. Other significa	ent condition	ns contributing to	death t	out not i	resulting I	n the unc	leriyin	g cause given in	Part I	24a. WAS AN PERFOR	MEO?	24	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
										1	•		1 _ YES 2 _ NO

					1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATH (C	heck only one)	
1 YES 2 DNO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	DOA 4 Nu	R: Insing Home 5 - Residence	a Other (Specify)	
27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c, INJURY AT WORK? 1 YES 2 NO	28d. DEŞCRIBE HOW INJURY OCCUP	REO
3 Suicide a Could not be determined	28s. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify)			28f. LOCATION (Street and Number or City or Town, State)	Rural Route Number,

29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

b. SIGNATURE AND TITLE OF CERTIFIER	M.D.	D372-34	29d. DATE SIGNEO (Month, Day, Year) ▶ 3 17 93

30. NAME AND JOORESS OF PERSON WHO COMPLETED CAUSE OF OBATH (ITEM 27) (Type, Print)

CARDLYN HENDRICKS, MM 14808 PHYSICIANS

31. DATE PLED MAINLY, Day, Year

32. SEGISTRASIS SIGNATURE

Fina Day door Person

32. SEGISTRASIS SIGNATURE

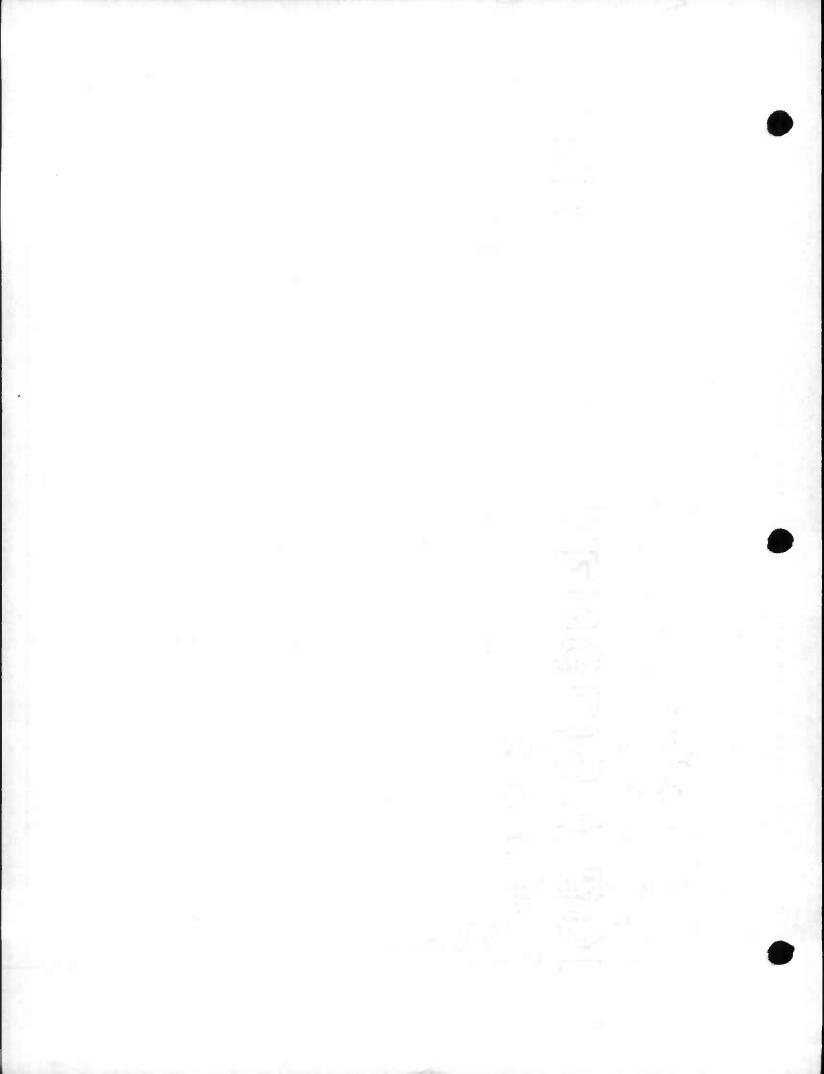
Fina Day door Person

31. DATE PLED MAINLY, Day, Year

32. SEGISTRASIS SIGNATURE

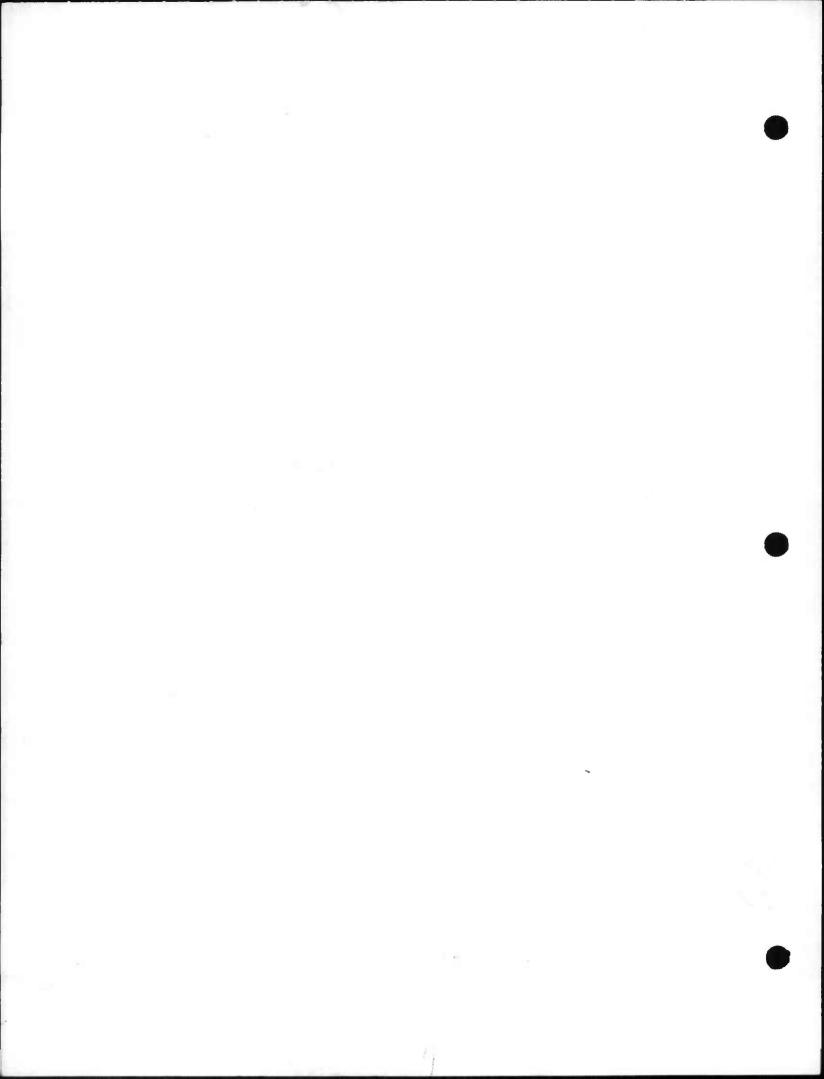
Fina Day door Person

32. SEGISTRASIS SIGNATURE



200 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C 1 C	rSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should thin the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
	YSICIAN: The law requires that the death certificate be execute	s certificate has been signed by the attending physician and completely filled in by the fi th the State Dept. of Health and Mental Hyglene prior to bunial, cremation, or removal.	d, or item 23 shows any injury, or other traumatic	
-	HE BISHTAL OR ATTENDING PHY	THE FUNDAL DIRECTOR: After this this after death with	ORTANT: if item 28 is marked	

FOR STATE REGISTRAR	STATE OF MARY	(LAND / DEPARTM CERTIFIC			MENTAL HYGIEN				
1. DECEDENT'S NAME (First, Middle, Last)				BEATT			3. TIME OF DEATH		
Mary M.	Clark				2. DATE OF DEATH MONTH 3	AY (17 92	1155 Ph- H		
4. SOCIAL SECURITY NUMBER	5. SEX 6. AC	E (In yrs. last birthday)	UNDER I YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	6. BIRT	HPLACE (State or Foreign		
216-12-0592	1 □ M 2 💢 F	98 'RS. MOI	NTHS DAYS	HOURS MIN.	(Month, Day, Year)	Cour	yland		
9a. FACILITY NAME (If not institution, give	street and number)	96	CITY, TOWN C	OR LOCATION OF D	- m	9c. COUNTY OF			
GOLDO OAK	dieno	T	Aure		1	Prince			
10a. STATE 10b. COUNT	Υ	10c. CITY, TO	OWN OR LOCAT	TION			10d. INSIDE CITY		
Maryland Prin	nce George's		Bowie				LIMITS?		
10e. STREET AND NUMBER				. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?		
8618 Maple Ave.				20720		Unit	ed States		
11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPAI	HC DRIGIN? (Specify Ye				
1 Never Married 2 Married	FORCES? 1 YE	S 2 ND	It yea, sp	ecify Cuban, Mexico 2 NO Specif	n, Puerto Rican, etc.)	Bla	DE — American Indian, ck, White, etc. city:		
3 Widowed 4 Divorced			', 123	2 Se iio spacii		145	hite		
15. DECEDENT'S EDU (Specify only highest grade	JCATION completed)	16a. DECEDENT'S USL (Give kind of work	JAL OCCUPATIO	ON	16b. KIND OF BU	SINESS/INDUSTRY			
Elementary/Secondary (0-12)	College (1-4 or 5+)	life Do NOT use re	tired.)	Si Gi Working					
9		Homemak	ter		Own Ho	ome			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Sumeme)			
John W. Lloyd				France	s Macabee				
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADI	DRESS (Street a	and Number or Rural	Route Number, City or Tow	n, State, Zip Code)			
John Mullikin		14006 0	ld Cha	pel Rd.	Bowie Md.	20715			
20a. METHOD OF DISPOSITION		OR PLACE AND DATE OF D	ISPOSITION /No	me of	DATE 200 LC	CATION CHARAC	own, Stata		
1 Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	novel from State	Ascension	Cathol:	ic Churc	h 3/11/93	Bowie	Maryland		
21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		22 NAME AN	P ADDRESS OF FA	cury Funeral Ho	DOWLE	narytana		
▶ Robert E.	Evans.	Tras-			Funeral Ho lis Rd. Bo				
23. PART I. Enter the diseasea, pr	complications that caus	sed the death. Do not	enter the mo	de of dying, suc	h aa cardiac or reap	iratory arrest,	Approximate		
ahock, or heart fallure. iMMEDIATE CAUSE (Final	List Dnly Dne cause Dr	each iina.					Interval Between Onset and Death		
disease or condition resulting in death)	CARDI	0- Respi	ROVO	my &	PREST		MINUTES		
resulting in death)	se or condition ing in death) a. CARDIO - RESPINS VOR DUE TO (OR AS A CONSEDUENCE OF):						1		
CARDING ARRITHUIS									
Sequentially list conditions, if any, leading to immediate	equentially list conditions,					11. + Dinasa succession			
cause. Enter UNDERLYING CAUSE (Disease or injury	c ART	anco sol	ERO G	c /46	on D	158058	- YESNS		
that initiated events	DUE TO (DR A	A CONSEQUENCE DF):			. 3	11 /			
resulting in death) LAST	d. DENI	Li Ly.	DEH	4 Drag	TON 2	4 kg.	YEARS		
PART II Other significant condition	no opatributing to do at			1			1/		
PART ii. Other significant condition	na contributing to death	Dut not resulting in the	ne underlying	¢ause given in	Part I. 24s. WAS AN PERFOR		b. WERE ANTOPSY FINDINGS AVAILABLE PRIOR TO		
					1 _ YES 2	1216	COMPLETION OF CAUSE OF DEATH?		
							1 TES 2 NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Ch	eck only one)				
	1 Inputiont 2 ER/O		HER:	e 5 🗆 Residence	6 Other (Specify)				
1 TYES 2 TO NO	27. MANNER OF DEATH 280. DATE OF INJURY 280. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED								
1 TYES 2. AND 27. MANNEW OF DEATH	28e. DATE OF INJUR		14/0						
1 YES 2. NO 27. MANNER OF DEATH 1 Netural 5 Pending			M 1 V	ES 2 NO					
1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be	28e. DATE OF INJUR (Month, Day, Year 28e. PLACE OF INJU	r) INJURY	M 1 🗆 Y	ES 2 NO	281. LOCATION (Street	and Number or Rural	Route Number,		
1 YES 2 NO 27. MANNEN OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26e. DATE OF INJUR (Month, Day, Year	r) INJURY	M 1 🗆 Y	ES 2 NO	281. LOCATION (Street City or Town, State)	and Number or Rural	Route Number,		
1 YES 2 NO 27. MANNEN OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be defermined	28e. DATE OF INJUR (Month, Day, Yea 28a. PLACE OF INJU- building, atc. (S	RY — At home, tarm, stree	M 1 1 Y	ES 2 NO	City or Town, State)		Route Number,		
1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be defermined 29a. CERTIFIER (Check only)	28e. DATE OF INJUR (Month, Day, Yea. 28e. PLACE OF INJU building, etc. (S	RY — At home, term, stree pecify)	M 1 1 Y	ES 2 NO	City or Town, State) to the cause(s) end mai	nner as stated.			
1 YES 2 MO 27. MANNEN OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be defermined 29a. CERTIFIER (Check only 0ne) 2 MEDICAL EXAMINE	28e. DATE OF INJUR (Month, Day, Yea.) 28a. PLACE OF INJU- building, stc. (S	RY — At home, term, stree pecify)	M 1 1 Y	res 2 NO	to the cause(s) and mad time, data and place, an	nner as stated.	a) and manner as stated.		
1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be defermined 29a. CERTIFIER (Check only)	28e. DATE OF INJUR (Month, Day, Yea.) 28a. PLACE OF INJU- building, stc. (S	RY — At home, term, stree pecify)	M 1 1 Y	ES 2 NO	to the cause(s) and mad time, data and place, an	nner as stated.			
1 YES 2 NO 27. MANNEN OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be defermined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29a. BEGNATURE AND TITLE OF CERTIFIER	28e. DATE OF INJUR (Month, Day, Yea 28e. PLACE OF INJU building, etc. (S ICIAN: To the best of my kn ER: On the best of axamine	RY — At home, tarm, stree occity) owledge, death occurred at tion and/or investigation, in	M 1 V	res 2 NO	to the cause(s) and mad time, data and place, an	nner as stated.	a) and manner as stated.		
1 YES 2 MO 27. MANNEN OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be defermined 29a. CERTIFIER (Check only 0ne) 2 MEDICAL EXAMINE	28e. DATE OF INJUR (Month, Day, Yea 28e. PLACE OF INJU building, etc. (S ICIAN: To the best of my kn ER: On the best of axamine	RY — At home, tarm, stree occity) owiedge, death occurred at tion and/or investigation, in	M 1 V	and place, and due eath occured at the 29c. LICENSE NUM	to the cause(s) and mad time, data and place, an	nner as stated.	a) a <i>nd</i> manner as stated.		



BALTIMORE, MARYLAND 21215-0020

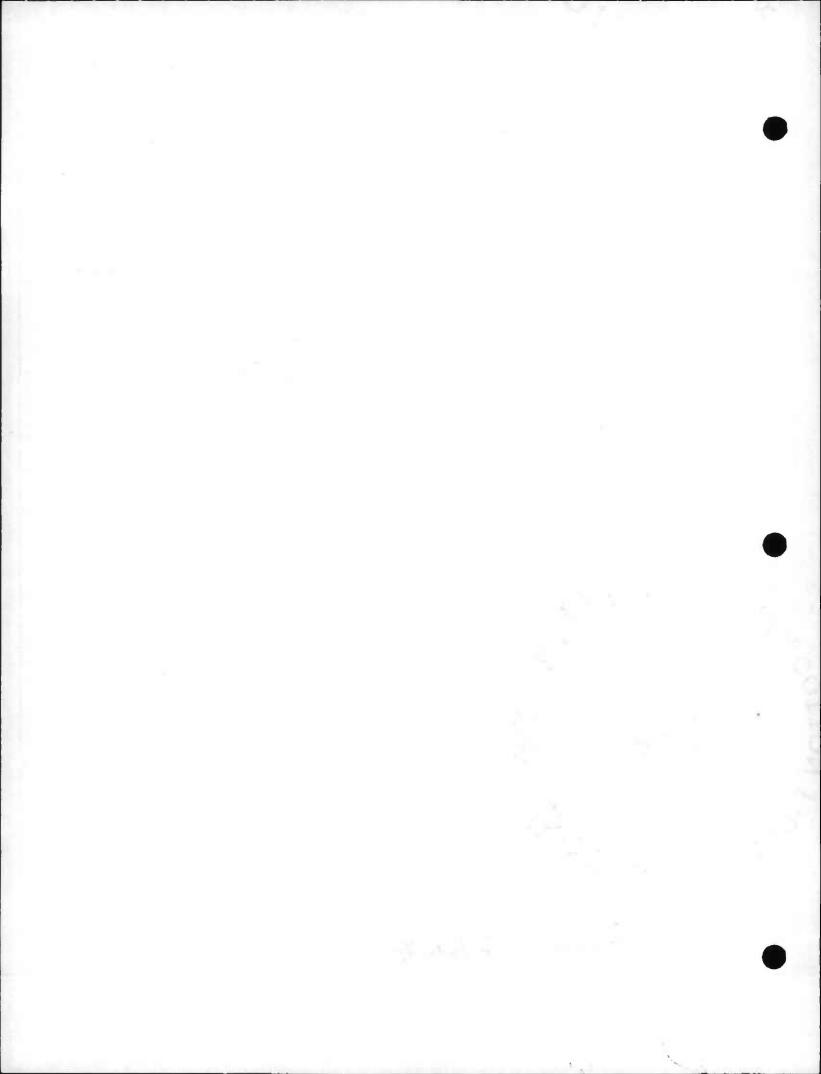
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HIGH TOWNING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE HIGHAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene pilor to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Lest) Cecilia	D. (Coffman			2. DATE OF DEATH DO NONTH DO February		
2	4. SOCIAL SECURITY NUMBER 199–12–6800 9e. FACILITY NAME (If not institution, give s:	1 □ M 2XXF 82	YRS. MO	UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) February	6,1911	PETHPLACE (State or Foreign punitry) Penn.
OR	1852 Severn Gro		98	o. City, town o	Annap		e. county of	e Arundel
딥	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	7	10c. CITY. TO	OWN OR LOCAT	ON			10d. INSIDE CITY
DIRECTOR		Arundel		polis	34			1\times 2 \tag NO
FUNERAL	1852 Severn	Grove Road		101.	ZIP CODE 21	401	10g. CITIZEN (U.S.A.
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Midowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 100	If yes, spe		IC ORIGIN? (Specify Yer n, Puerto Rican, etc.)	S	ACE — American Indian, Slack, White, etc. Specify: JCASIAN
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	completed)	16a. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during mos	N It of working	16b. KIND OF BU	SINESS/INDUSTR	W .
APL!	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	Adminis	strativ	e Assist		olic Hea	alth Service
BE CON	17. FATHER'S NAME (First, Middle, Lest) Zigmund Gar	linsky			18. MOTHER'S NAI	ME (First, Middle, Malden a Ziemi		
TO B	196. INFORMANT'S NAME (Type/Print) Girard C. Coffm	an		DRESS (Street a)		loute Number, City or Tow	n, State, Zip Code)
	20a_METHOD OF DISPOSITION ALBuriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State 20b.	PLACE AND DATE OF D etery, cremetory or other	place)	tors 2	10 02	CATION — City o	backway F
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSPÉ)		22. NAME AN	D ADDRESS OF FAC	Lee Fur	neral Ho	ome, Inc. Linton, Md2073
	23. PART I. Enter the diseases, proshock, or heert fellure.	complications that ceused List only one cause on e	I the death. Do not ech line.	enter the mod	le of dying, suct	as cardlec or resp	ratory arrest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	CAF	= and	el (coron	any ar	t. di	Onset and Death
N	Sequentially list conditions,	· age	2			(
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	с	CONSEQUENCE OF):					
CER	resulting in death) LAST	d	<u> </u>					
MEDICAL	PART II. Other significent condition	s contributing to deeth b	ut not resulting in t	he underlying	ceuse given in	Part I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
. ME								1 PES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				ACE OF DEATH (Che	ick only one)		
YSIC	1 TYES 2 X NO	HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/Outp		THER: Nursing Home	5 N Residence	6 Other (Specify)		
	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME O	WOI	PRY AT RK? ES 2 NO	28d. DESCRIBE HOW I	NJURY OCCURE	
rED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spee	— At home, farm, street			281. LOCATION (Street City or Town, State)		irel Route Number,
COMPLET	onel	CIAN: To the best of my knowles: On the beels of examination						se(s) and manner as stated.
BE C	296. SIGNATURE AND PITLE OF CERTIFIER	k o.l.			29c. LICENSE NUM	A-514.1	29d. DATE SIG	NED (Month, Day, Year)
10	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Time 12-	nd l	D2471		12/	18 93
	Dr. William		ain (iism 27) (type, Pri	60		y Avenue S	Suite 12	20
	31. DATE FILED WART 1993 32. REGISTRAR'S SIGNATURE Appapolis, Maryland June Davidson Randele							



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

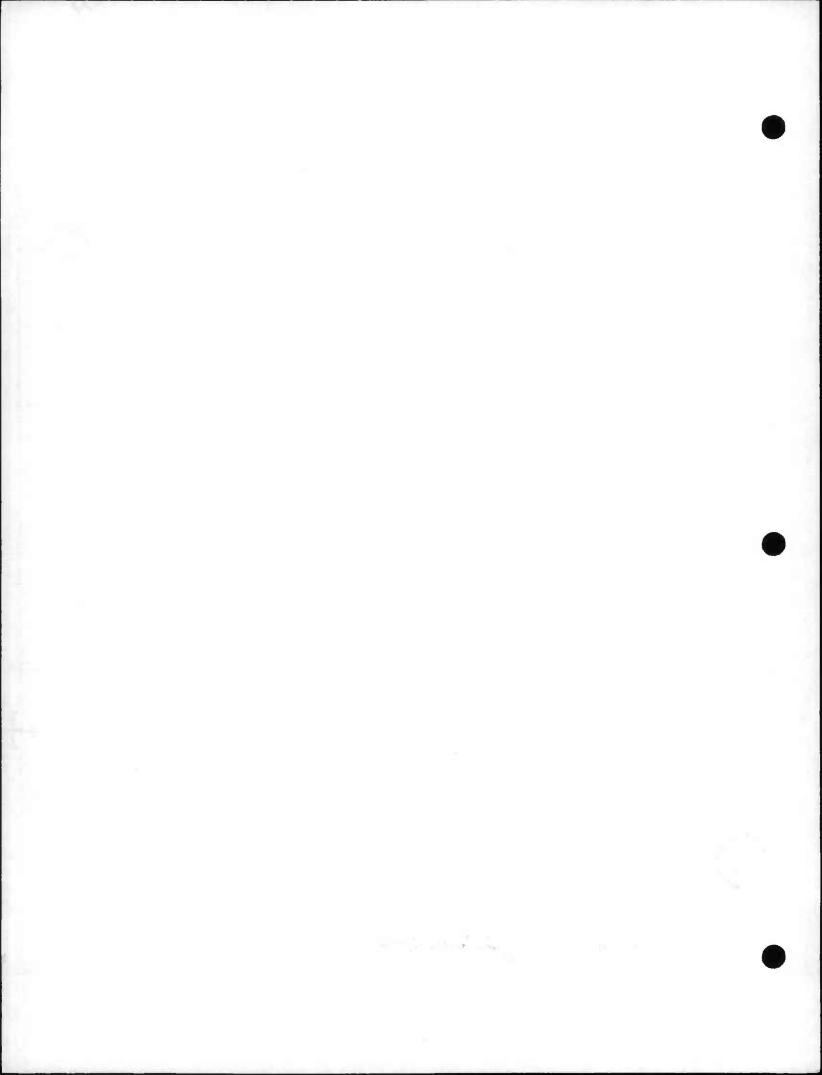
Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be the control of the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

INTELLIP MINIOR 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

	REGISTRAR				ERITE	ICALE	OF DE	AIH	R	EG. NO.			
	1. DECEOENT'S NAME (First, ANNA M		et CARSO	N					2. DATE OF C	DEATH DAY		YEAR 93	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yrs. i	lant hirthrian	IF UNDER 1 Y	TAR E IN	DER 24 HRS.	7. DATE OF B		—-т		6 28A M
	213-10-1737		1 M 2 XF	87	YRS.		AYS HOUR		(Month, Day	y, Year)		B. BIRTHI Country	PLACE (State or Foreign
				07	rna.				L 9/18.	/1905			imore Md.
00	9a. FACILITY NAME (If not institution, give street and number)					9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH						EATH	
DIRECTOR	RESIDENCE OF DECEDENT						ERLY				PRIN	CE G	EORGE'S
2	10a. STATE	10b. COUNT			10c. CIT	Y, TOWN OR I							10d. INSIDE CITY LIMITS?
											1 TYES 2 NO		
FUNERAL	10e, STREET AND NUMBER						10f. ZIP C	ODE			10g. CITIZ	ZEN OF W	HAT COUNTRY?
15	7415 AII	ison S	St.					2078	H				IISA
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.	ARMED			T OF HISPAN	IC ORIGIN? (S		r No—	14. RACE	
BY F	1 Never Married 2 3 XWidowed 4 Divo		IF YES, GIVE W	YES 2 MAR OR DATES	3NO	1 [YES 2	uban, Mexica NO Specify	n, Puerto Ricar	ı, etc.)		Specify	- American Indian, White, atc. White
ETED	15. DEC (Specify only	EDENT'S EDU	CATION completed)			USUAL OCCL		orkina	16b. KIN	D OF BUSI	NESS/IND	USTRY	
	Elementary/Secondary (0	7	College (1-4 or 5		fe. Do NOT us	e retired.)							
M P	3				Hous	ewife				Own	Hon	ne	
COMPL	17. FATHER'S NAME (First, Mi	iddle, Last)					18. M	OTHER'S NA	ME (First, Middle	e, Meiden Sc	umame)		
BE	George	Shaw						Bai	rhara	Pitsir	ager		
2	19a. INFORMANT'S NAME (7)								Route Number, C				
-	Margare		Royer		7415	Alliso	n St	., Lai	ndover	Hill	s, M	ld. 2	20784
	20s. METHOD OF DISPOSITI		ioval from State		EAND DATE	OF DISPOSITION	N (Name of		DATE	20c. LOCA	ATION — (City or Tow	vn, Siete
	4 Donation 5 Other					In Cer			3/5/9	B Br	centy	wood	Md.
	21. SIGNATURE OF FUNERAL	L SERVICE LI	CENSEE		/			FLIDO		mo I	1720	Ralt	imore Ave.
	Yac	ke d	X Fre	end	-				Md. 20		1133	Dail	illiore Ave.
	23. PART . Enter the di	seesea, or	complications the	t caused the	deeth. Do r	not enter the	mode of	dying, suci	h as cardiac	or respira	itory arr	est,	Approximate
	IMMEDIATE CAUSE (Fin		List only one ceu	se on each ill	ne.								Interval Between Onset and Death
	dispase or condition resulting in death)	→	. Set	stic	_ <	shi	T K						
	resulting in death)	,	DUE TO	(DR AS A CONS	EQUENCE O	F):	0	1	,	1	4		
z			· Acu	ili	HE	mo	il	4	2U	W	16	7	
일	Sequentially list conditi if any, leading to immed	diate	DUE TO	(OR AS A CONS	EQUENCE O	F):	1		0 1	2	10	~	100
2	cause. Enter UNDERLYi CAUSE (Disease or inju		. Jypt	erler	YOV-	6 (5	nde	6 Val	scul	di	de	514	se
	that initiated events resulting in deeth) LAS		OF TO	(DR AS A CONS	EQUENCE OF	T):	100		-1-	0		Sta	
CERTIFICATION	Tooling in donly and		d. 0/1	o No	29	FY	10	(4)	OU	200	2	~	
	PART II. Other algnifice	nt condition	s contributing to	death but not	reaulting	n the unde	rlying çaus	e given in	Part I. 24a	. WAS AN A			WERE AUTOPSY FINDINGS
EDICAL	ang	M	ic R	101	in	SUM	de	on	0.	PERFORM			AMAILABLE PRIOR TO COMPLETION OF CAUSE
			7		-				-	3 123 2			OF DEATH? 1 YES 2 NO
2									-				T IES Z INO
PHYSICIAN:	25. WAS CASE REFERRED TO	MEDICAL					26. PLACE O	F OEATH (Che	ock only one)				
Sic	EXAMINER?		HOSPITAL:	ER/Outpatient	3 DOA	OTHER:	Home 5	Residence	8 Other (Sp	ecify)			
ξÌ	27. MANNER DF OEATH		28s. DATE DF		28b. TIM	E OF 28	c. INJURY AT		28d. OESCRIE		JURY OCC	URED	
ВУ Р		Pending investigation	(Month, D	ay, Year)	INJ	M 1	WORK?	2 🗆 NO					
	2 Sudates	Could not be	28e. PLACE O	F INJURY — At I	home, farm,	street, lectory,	offics		281. LOCATIO	N (Street and	d Number	or Rural Ri	oute Number,
TED		determined	building,	atc. (Specify)				- 1	City or To	wn, State)			
벌	29a. CERTIFIER	IFYING PHYS	ICIAN: To the best of	my knowledge	death occurs	ed at the time	date and of	ene and due	to the enumeral) and man			
COMPLET													and manner as stated.
	195. SIGNATURE AND TITLE												
出	+Caki	2/1	CIM	2/01	15	NN	7	JCENSE NUN	I A S	- 1	290. DATE	SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WI	D COMPLETED CALIF	SE OF DEATH (IT	FM 27) (700	Print)		رک	UX			5 5	5/7.5
					_m = 1 17 19 10								,
	31. DATE FILED MARK ()	8 199	32. REGISTRA	R'S PIGNATURE	- Hande	ee							



THE HOSE FOLK OF AN AND PHYSICIAN: The law requires that the death certificate be executed writh a remain and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fined within 72 for use as the burial-transit permit. Pages 1, 2, 3 should be fined within 72 for each with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

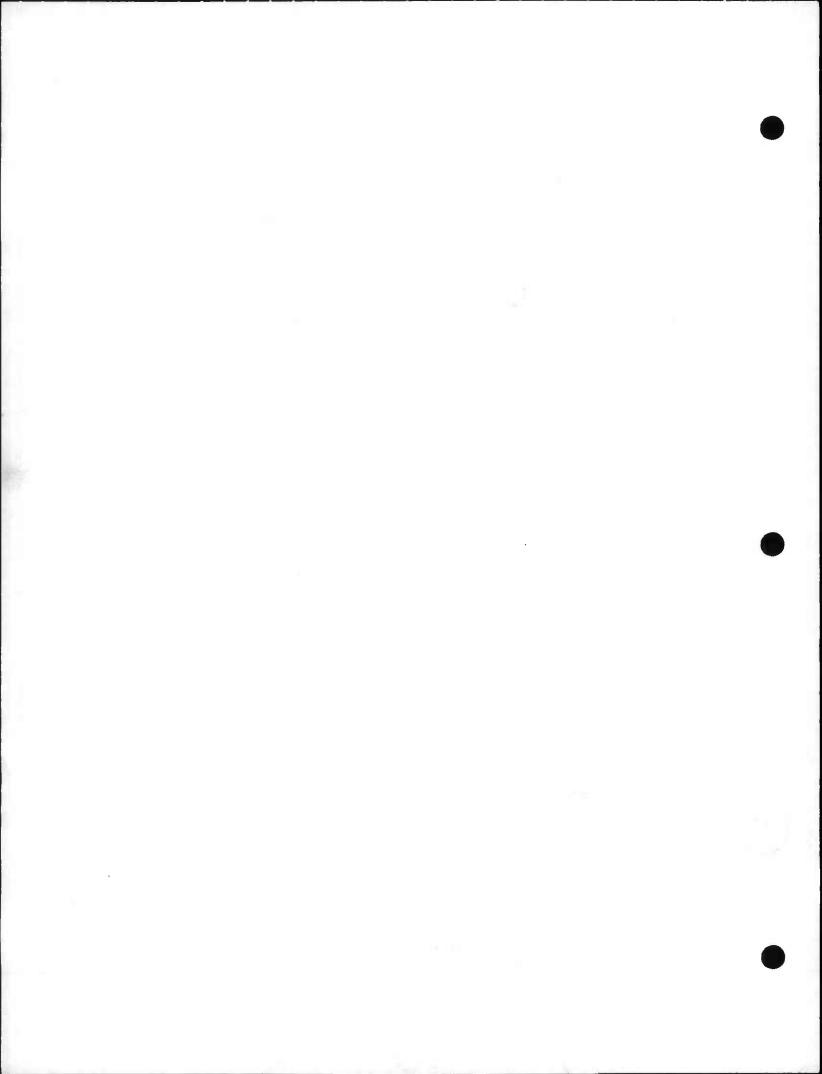
Benjamin Aurunin, M.D.

32. REDISTRAR'S SIGNATURE
Seria Van doop-Randalle

31. DATE FIRM ART (0°, 5°, 1993

ON OF VITAL RECORDS, P.O. BOX 68760,

					- Dau	gnter				93	08711
	FOR 1 - STATE REGISTRAR	STATE OF MA			ITMENT O			MENTAL HYGI REG.			
	1. DECEDENT'S NAME (First, Middle, Last)						$\neg \neg$	2. DATE OF DEATH	DAY	YEAR 3.	. TIME OF DEATH
	MIRIAM MONCAYO	CADENA			Saguio	cela		03	05	93	1:20am w
	4. SOCIAL SECURITY NUMBER 220-35-8175	5. SEX 6.	AGE (In yrs. les	t birthday) YRS.	IF UNDER 1 YE MONTHS DA		MIN.	7. DATE OF BIRTH (Morith, Day, Yea March 2	,1949	8. BIRTHPL Country)	ACE (State or Foreign Cuador
	9a. FACILITY NAME (If not institution, give st	reet and number)		9b. CITY, TOWN OR LOCATION OF DEA				ATH	9c. CO	UNTY OF DEA	тн
6	MONTGOMERY GENERAL HOSPITAL				OL	NEY			MON	VIGOME	RY
[E	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	,		10c. CIT	10c. CITY, TOWN OR LOCATION 10d INNER						Od. INSIDE CITY
DIRECTOR		gomery		Silver Spring							LIMITS?
FUNERAL	14220 Weeping Wi	llow Drive	e, #11			101. ZIP COD 2090		10g. CITIZEN OF WHAT COUNTRY? Ecuador			AT COUNTRY?
3	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. AR	MED	13. WAS	DECENDENT (OF HISPANI	IC ORIGIN? (Specify	Yes or No-	14. BACE -	- American Indian,
B	1 Never Married 2 And Married 3 Widowed 4 Divorced	FORCES? 1 THE IF YES, GIVE WAR		10		I, specify Cube YES 2 NO	Specify:	i, Puerto Rican, etc. Ecuadori	an		White
<u>a</u>	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a, DE	CEDENT'S	USUAL OCCUI	PATION		16b. KIND OF	BUSINESS/IN	NOUSTRY	
COMPLETED	Elementary/Secondary (0-12) 12	College (1-4 or 5+)	ino.		work done during se retired.) Maker			Own	Home		
S S	17. FATHER'S NAME (First, Middle, Last)							ME (First, Middle, Mai			
BE (Jacinto Moncayo]	Robalino						ster Cad			
2	Galo Gonzalez		14	220	Weepin	g Will	OW D	oute Number, City or r.,#11,S	ilver	Sprin	ng MD 20906
	20a, METHOD OF DISPOSITION XX Burlat 2 Cremation 3 Remo	oval from State	cemetery, cre-	matory, or o	of DISPOSITION		nm` 2.	DATE 200		- City or Town	
1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	paran	I TOCK		E AND ADDRE			Jayaqı	TII, E	Cuauor
Ш	· Jeff Their	~			9013	Annap	olis	Rd. Lan	Fane.	arylan	d 20706
	23. PART L Eres the diseases, or c shock, or heart fallure. I	omplications that collect only one cause	nused the de	ath. 90 i	not enter the	mode of dy	Ing, such	as cardiac or re	spiratory a	rrest,	Approximata
	IMMEDIATE CAUSE (Finel	<u></u>	Oli olilor illini	1/2	000						Interval Between Onset and Death
	disease or condition resulting in death)	w	re 1	Key	KO 4	La					
z	-	BUE TO (OF	AS A CONSEC	A DO	FIL 1 D JAJ	\ .		0 4 . 1			
ᅙ	Sequentially list conditiona, if any, leading to immediate	DUE TO (OF	AS A CONSES	UENCE	P): 4		NC	A	1	A	-
2	CAUSE (Disease or Injury	. Hew	9	ld	ula	17	SAG	eral	u 6	Stall	(L)
ERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OF	AS A CONSEC	DUENCE O	F): V		9		1		
핑		·									
¥.	PART II. Other significant conditions	s contributing to de	eth but not n	esulting	In the under	ying cause	given in f		AN AUTOPSY FORMED?		PERE AUTOPSY FINDINGS
EDICA								1 _ YES	2 X NO	CC	OMPLETION OF CAUSE OF DEATH?
Σ								_		1	YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL										
SICIAN:	EXAMINER?	HOSPITAL:	Translation.	= .w	OTHER:	B. PLACE OF D					
PHYS	27. MANNER OF DEATH	28a. DATE OF INJ	URY	28b, TIM		Home 5 - Re	-	8 Other (Specify) 28d. DESCRIBE HC	W IN THEY OF	CCUBED	
	1 Netural 5 Pending	(Month, Day,	(bar)	INJ	URY	WORK?	- 1	Zeu. DESCRIBE NO	W INSONT O	CONED	
ЭВУ	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF IN	JURY — At ho	me, ferm, :			-	281. LOCATION (Str	et and Numbe	er or Rural Rou	ite Number,
U 4 ☐ Homicide determined determined											
2	29a. CERTIFIER (Check only	CIAN: To the best of my	knowledge, de	ath occum	ed at the time,	data and place	, and due t	to the cause(a) and	manner as st	ated,	
COMPLET	One) 2 MEDICAL EXAMINER										nd manner as stated.
l w II	296. BIGHATURE AND TITLE OF CERTIFIER	20	1			29c. LICI	ENSE NUM	BER	29d. DA	TE SIGNIO	torrity Clary House
TO B	Trust i	100 kg	tu	-			35	362	•	3/5	193
F	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE (F DEATH (ITEM	1 27) (Type,	Print)	Dani	JIDA A	01	Ma	1 1	20022
1 1	Benjamin Aurunin,	M.D. 1811	ı Prin	ice P	иттъ	υrive,	#1114	, Olney,	Mary.	Land	20832



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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH 3/2/93 YEAR 3. TIME OF DEATH 1PM Joncelyn JOYCELYN V. COZIER-DAINTY 93 Daint 2 ٦. 4. SOCIAL GECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BURTH a. BIRTHPLACE (State or Foreign 578-88-3526 May 25, 44 HOURS Güyana 1 🗌 M 2 🔲 F 1948 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH HOLY CROSS HOSPITAL DIRECTOR Silver Spring, Maryland Montgomery County RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Montgomery Silver Spring YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8811 Colesville Road 20910 funeral director, page 5 should be detached for use as the burial-transit U. S. A. retained by the hospital or attending physician. 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black White etc. If yes, specity Cuban, Mexican, Puerto Rican,

1 YES 2 XWO Specify: 1 Never Married IF YES. GIVE WAR OR DATES ВУ 3 Widowed 4 X Divorced African-American COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Four Years Elementary/Secondary (0-12) Registered Nurse Private Industry once. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surname) ¥ Ernest Cozier Princess Belle BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ACORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Gloria Cozier 939 Bishop Power LaSelle, Montreal, Canada pe 20e. METHOD OF DISTINON

1 Warriel 2 Cremetion 3 - Removal from State 24 hours after death. Page 6 may 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE 1 Murtal 2 Cremetton 3 4 Other (Specify) must Harmony Memorial Park 3/8/93 Landover, Maryland examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Johnson & Jenkins Inc. 20011 716 Kennedy Street, N.W., Washington, D.C. filled in by the figure, or removal. medicai 23. PART / Enter the diseases, or completions that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ehock, or heart feliure. List only one cause on each line. Approximate Interval Between IMMENATE CAUSE (Finel Onset and Death cremation. the disease or condition reaulting in death) Pos. Gram regulive signed by the attending physician and completely the atth and Mental Hygiene prior to burial, crematic within event, OUE TO (OR AS A CONSEQUE traumatic Need CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate requires that the death certificate be cause. Enter UNDERLYING CAUSE (Disease or injury other OUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 10 injury, PART II. Other significent conditione contributing to death but not recuiting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 TYES 2 T NO shows : assus, 1 - YES 2 - NO been it. of has be Dept. PHYSICIAN: I: The law 23 25. WAS CASE REFERRED TO MEDICAL Item 28. PLACE OF DEATH (Check only one) the State 1 **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA me 5 - Rasidence 6 - Other (Specify) the 6 28e. OATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28h TIME OF 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCURED is mached. 1 Netural 1 YES 2 NO ВҰ 2 Accident 28a. PLACE OF INJURY — At home, farm, street, lecto-building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the beet of my knowledge, death occurred at the time, data end place, and due to the cause(s) and menner as steted. FUNERAL WITH 72 h TAME: If I 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(a) end manner as stated. TO THE PLACERA be filed within 7 29b. SIGNATURE AND TITLE OF CERTIFIER 29d, DATE SIGNED (Month, Day, Year) BE 3 3 89 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3, 9 些302 and RAJVAN SMI

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1993

32 REGISTRAR'S SIGNATURE

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jury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSP ALL CONTROL PHYSICIAN: The law requires that the	a g	IMPORTANT: IT was its marked, or item 23 shows any Ir	TO BE COMPLETED BY PHYSICIAN: MEDICA
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	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR ERTIF	RTMENT	OF H	EALTH	AND	MENTA	L HYGIE				
	1. DECEDENT'S NAME (First, Middle, Last) Namie	Loui									2. DATE OF DEATH FEDRUARY 28, 1993			Н
	4. SOCIAL SECURITY NUMBER 213-16-0360	5. SEX	51 11 da (111 y 12. 14			MATERIAL PLANTS LIGHT			7. DATE	OF BIRTH		e BIETH	3:45 A	wign
~	90. FACILITY NAME (If not institution, give s	treet and number)		YAS.	9b. CITY		A LOCATIO		EATH 9c. COUNTY OF			TY OF D		1
DIRECTOR	Frederick Memori RESIDENCE OF DECEDENT 100. STATE 10b. COUNT		. Call				rede	rick	ζ		<u> </u>	Fre	derick	4
	Maryland	Frederi	.ck	10c. CIT	Y, TOWN C	Fred	leric	k				10d. INSIDE CITY LIMITS? 1 YES 2	NO	
FUNERAL	100. STREET AND NUMBER 4332-A Basford R	load				101.	ZIP CODE		21702)	10g. CITI		S.A.	
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES?	NT EVER IN U.S. AR	AMED NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuben, Mexican, Puerio Ricen, etc.) 1 YES 2 NO Specify: Specify: White, etc.						, White, etc.			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementery/Secondery (0-12)		(G	CEDENT'S live kind of v	work done o sa retired.)	during mos	N st of working	g	16b	KINO OF BU		USTRY		
OMP	17. FATHER'S NAME (First, Middle, Last)			Home	make	r	18, MOTH	IER'S NA	ME (First, I	Ho Middle, Melder				
BE	Frederick Nelson 190. INFORMANT'S NAME (Type/Print)	Ramsbur	0	b. MAILING	ADORESS	(Street a	nd Number			theri			gh	
5	Mrs. Carla E. Di	ck		11754	Day	svil	le R	oad,	Fre	deric	k, Ma	ryla	nd 21701	
	A Burlet 2 Cremetton 3 Removed from State Comparison										nd			
	21. SIGNATURE OF UNERAL SERVICE LICE	C. Basp	he MC	00021		Kee		and	Basi	ord F			me rick. Md	1
	23. PART I. Enter the diseases, or o shock, or heert feliure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	omplications (he List only one cau	et coused the de use on each line	eth. Do r	Wen-	the mod	de of dyli	ng, suci	h es cerc	liec or resp	piratory arm	est,	Approximatinterval Bet Onset and	te tween
TION	DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditions, If any, laeding to immediate DUE TO (OR AS A CONSEQUENCE OF):													
ERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in death) LAST	OUE TO	(OR AS A CONSEC	DUENCE OF	F):									
MEDICAL CE	PERFORMEO? ANARL COMM 1 YES 2 NO OF DI									WERE AUTOPSY FINI AVAILABLE PRIOR TO COMPLETION OF CA OF DEATH? 1 YES 2 NO	USE			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER	1:			ack only on					_
166	27. MANNER OF DEATH 1 Neturel 5 Pending	1 Inpatient 2 28e. OATE OF (Month, D	INJURY	28b. T/M		28c. /NJU WOF	IRY AT		8 Other	(Specify)	INJURY OCC	URED		
ED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE O building,	F INJURY — At horetc. (Specify)	me, farm, s	treet, facto				28f. LOCA	ATION (Street or Town, State,	and Number (or Rural Ro	oute Number,	

29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, DO 7186

29d. DATE SIGNEO (Month, Day, Year) 3 9

M.D., 814 Toll House Avenue, Frederick, Md. 21701 Philip Shapiro,

31. DATE FILEO (MONTO, POR YOU) 1993 32. REGISTRAR'S SIGNATURE Juna Junason-Handalle

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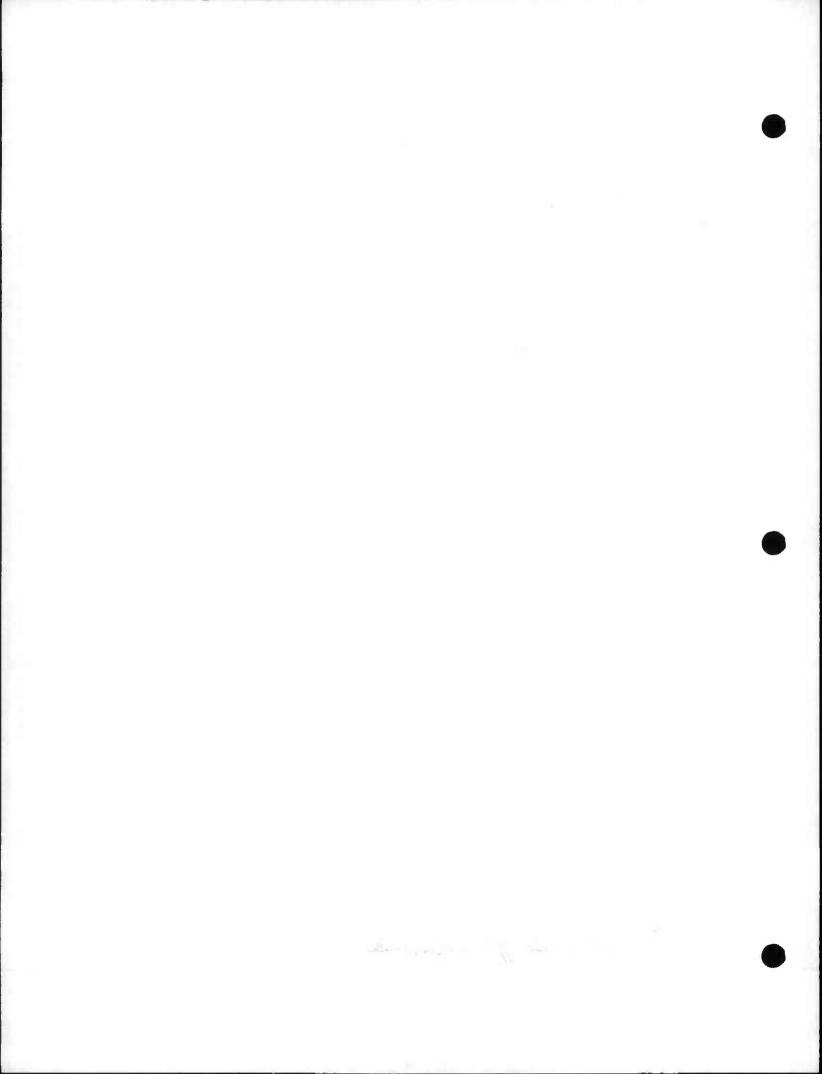
DHMH-16 Rev 1/99

1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1	1. DECEDENT'S NAME (Firs	A	. @)		Α				2. DATE OF DEATH			3. TIME OF DEATH
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	4. SOCIAL SECURITY NUM	BER		AGE (In yn	s. last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		6. BIRTHP	LACE (State or Foreign
d	218-20-	1941	11 M 2 □ F	65	> YRS.	mow i na	UATS	HOOMS	mrre.	5 28	1927		MD
	9a. FACILITY NAME (If not I	nstitution, give s	street and number)	. \	C. 0	9b. CITY	r, TOWN	DR LOCATI	ON OF DE	EATH	1	NTY OF DE	ATH
CTOR	RESIDENCE OF DE	CEDENT	e Hav.	HOS	pitch	1/4	201	kvi	116	PIB.	M	ont	90m er
DIME	10a. STATE	10b. COUNT			10c, Cl	TY, TOWN							IOd. INSIDE CITY
Md. Montgomery						Gaı	the	ersbu	ırg			1	YES 2 NO
2	100. STREET AND NUMBER			1	of. ZIP COD	• 208	179	U.S.A.					
FUNE	11. MARITAL STATUS		12. WAS DECEDENT E	VER IN U.S	. ARMED	13.	WAS DE	CENDENT (HC ORIGIN? (Specify Ye			- American Indian,
	1 Never Married 2		FORCES? 1 X	YES 2 OR DATES	□ NO]	If yes, s		ın, Mexica	n, Puerto Rican, etc.)		Black,	White, etc.
- 1	3 Widowed 4 Div	_	Korean	Conf	flict				opoun			ороспу.	white
2	15. DEG (Specify on	CEDENT'S EDU ly highest grade	CATION completed)	164	(Give kind of life. Do NOT	work done	CCUPAT during n	TION nost of world	ng	16b. KINO OF BU	SINESS/INC	DUSTRY	
2	Elementary/Secondary (0-12)	College (1-4 or 5+) 4 VYS.				m 8	nage	er	G.	М.Д.	C.	
COMPC	17. FATHER'S NAME (First, A	Aiddle, Last)			_					ME (First, Middle, Maiden	7.3		
ш	Maurice	H. Ch	iswell							rie Wate			
2	19s. INFORMANT'S NAME (Type/Print)			196. MAILIN	G ADDRES	\$ (Street	and Number	or Rural I	Route Number, City or Tox	rn, State, Zip	Code)	(1 00070
	lean R C		11		1002	2 St	edv	VICK	Rd.	Gaither	sbur	g, r	1d.20879
	20s. METHOD OF DISPOSITION 1 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Monage of the plac												
4 Donation 5 Other (Specify) 17 OTTO CACY 37 J Deal IS VIII 19 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										· · · · · · · · · · · · · · · · · · ·			
	►11/10.		c 1114	-						eral Hom	ıe		
-	William C Kith Hilton Funeral Home Barnesville, Md. 20838 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
	shock, or heart feiture. List only one cause on each line.										Interval Between		
1	iMMEDIATE CAUSE (Final disease or condition resulting in death)								Onset and Dea				
	resulting in death)		DUE TO (OF	AS A CO	NSEQUENCE (- `						01.0
2	Sequentially list condit	ions (b										
	if any, leeding to imme cause. Enter UNDERLY	diate	DUE TO (OF	R AS A CO	NSEQUENCE (NF):							
2	CAUSE (Disease or Inju		c. OUE TO (OF	AS A CO	NSEQUENCE (NF):							-
CERTIFICATION	resulting in death) LAS	TT.	d.										
	PART ii. Other significa	ant condition	s contributing to de	ath but n	ot resulting	in the m	adadul.	22 221122	nluon in	Boot L Or years	LAICTORON	Tan I	
EDICAL	Transition and anguinous	unt condition	- Contributing to be	ath out n	ot resulting	III (III UI	icertyii	ng cause	given in	Part I, 24a. WAS AF PERFO		1	VERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE
										1 TYES	SAMO		OF DEATH?
2										_		1 '	YES 2 DIE
IAN	25. WAS CASE REFERRED 1 EXAMINER?	O MEDICAL					26. 1	PLACE OF D	EATH (Ch	eck only one)			
YSICI	1 TYES 2 NO		HOSPITAL:	R/Outpatier	nt 3 🗆 DOA	4 🗆 Nur		me 5 🗆 Re	esidence	8 Other (Specify)			
PH	27. MANNER OF DEATH 1 Natural 5	Pending	28a. DATE OF IN. (Month, Day,		28b. Til	JURY		JURY AT ORK?		28d. DEŞCRIBE HOW	INJURY OC	CURED	
à	2 Accident		М		YES 2	NO							
	3 Suicide 8 4 Homicide	Could not be determined	28e. PLACE OF It building, etc.	(Specify)	t nome, farm,	street, fac	tory, off	ice		28f. LOCATION (Street City or Town, State		or Aural Ro	ute Number,
	29a. CERTIFIER	TIPVINO BUYO			100000		2 - 52	los es		2			
COMPL	and the second		ICIAN: To the best of my IR: On the besis of exam										and manner as stated
	296. SIGNATURE AND THE								ENSE NUM			1000	Modelli, Day, Warr)
2	01	1	1.00		my				33	686	> 0	1/33	193
2	30. NAME AND ADDRESS O	F PERSON WH	O COMPLETED CAUSE	OF DEATH	(I) EM 27) (Typ	, miny	_		00	7 7 7		da,	1 /2/10
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	31. DATE FILED (MONT)	2 1 1°	98 32 REGISTRAR'S	SIGNATUL	RE YOU	.00				,		J	
- 1	MIH!	INTE	Julia,	Javidse	n-Rand	4.00						146	_

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



ed for use as the burial-transit permit. Pages 1, 2, 3 should

THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the ho	TO THE PAREMAL DIRECTOR After this sertificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach		IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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John A. Vitarello MD

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32. REGISTRAR'S SIGNATURE

1993

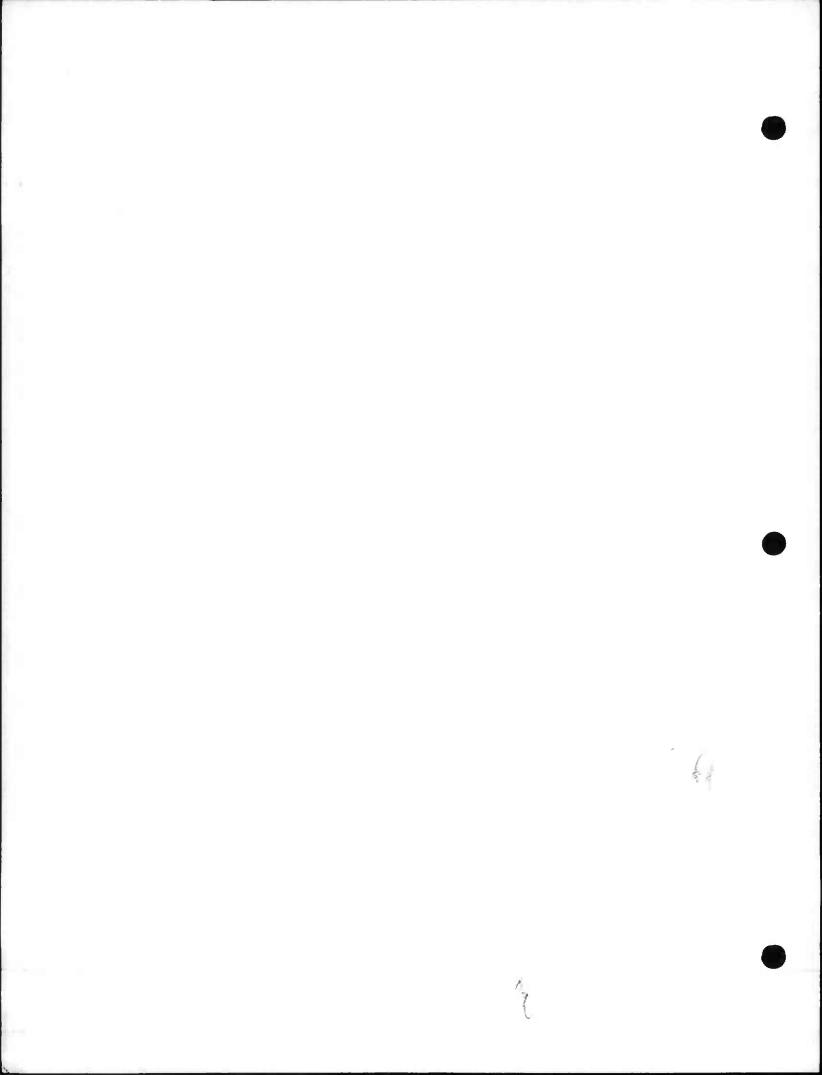
31. DATE FILED (Month, Day, Year)

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH BARBARA C. CROUCH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH BARBARA YEAR 2/22 PM 932 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Morith, Day, Year) 1/2/1931 HOURS 387-34-9036 1 M 1 F 62 YRS. Wisconsin 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Frederick Memorial Hospital Frederick Frederick RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Frederick Frederick 1X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1100 Evergreen Avenue 21701 U.S.A. 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Marrie IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 4 years Nurse 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at John Elliot Christensen BE Eleanor Slaasted 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Nancy Williford 247 Braeburn Circle Walkersville, Maryland 21793 must be 20s. METHOD OF DISPOSITION
1 Spuriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE | 20c. LOCATION - City or Town, State Mount Olivet Cemetery 2/25 Frederick, Maryland examiner 21. SIGNATURE OF FUNDRAL SERVICE LICE 22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. rek 1201 NORTH MARKET ST. FREDERICK, medical 23. PART I. Enter the diseases, or comply ed the death. Do not enter the mode of dying, such as cardiec or reepiratory arreet, Approximate Interval Between shock, or heart fellure. List only Onset and Death **IMMEDIATE CAUSE (Finel** in the disease or condition espiratory resulting in death) State Dept. of Health and Mental Hyglene prior to burial, crema flem 23 shows any Injury, or other traumatic event, DUE TO OR AS A CONSEQUENCE OF PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 25 NO ne 5 🗆 Residence 6 🗆 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, Natural м 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 29s. CERTIFIER
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(Ch 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND THE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Months Day, Year) BE D27544 Mo 112 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

310 West Ninth Street Frederick, Maryland 21701

Panda 90



	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPART	MENT OF H	EALTH AND I	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last) RALPH A.	CORBINAN	4 58			2. DATE OF DEATH DA	" q".	3. TIME OF DEATH			
	221-07-7831	S. SEX 6. AGE (In)	yrs. last birthday)	F UNDER 1 YEAR ONTHE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 7-1-20	BIRTHPLACE (State or Foreign Country) MI;				
OR	9a. FACILITY NAME (If not institution, give street Harbor Hospital	t and number)	9		Baltimore Baltimore Baltimore						
DIRECTOR	Harbor Hospital RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		TOWN OR LOCAT			2000	10d. INSIDE CITY				
	MD Baltir	more City	Balk	timore			LIMITS?				
FUNERAL	1224 S. Charles St.			101.	ZIP CODE	OF WHAT COUNTRY?					
BY FUN		2. WAS DECEDENT EVER IN U FORCES? 1V YES IF YES, GIVE WAR DR DATE	2 NO	MED O 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: 14. RACE Black, Specify Specify							
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	ION 16	Ba. DECEDENT'S US (Give kind of wor life. Do NOT use i	k done during mos	N t of working	16b. KIND OF BUS	SINESS/INDUST	White			
MPL		201094 (1-4 01 0 +)	Electr	ician		Maint	enence				
	17. FATHER'S NAME (First, Middle, Last) Fred	Corbman			Acelai	ME (First, Middle, Maiden .de Baxte					
3 BE	19a. INFORMANT'S NAME (Type/Print)	COLDIIIaII	19b. MAILING A	DDRESS (Street at		Route Number, City or Town		ie)			
안	Mark Corbman		126 A	rundel	Beach Ro	. Severna	Park,	MD 21146			
	20s. METHOD OF DISPOSITION 1 Surface Specify Cremation State Cremation State Cremation State Cremation State Cremation State Cremation State Cremation State Cremation State Cremation State Cremation State Cremation State Cremation State Cremation State Cremation State Cremation State Cremation Crem										
	21. RIGHATURE OF BATTERIAL SERVICE LICEN	See Sarra			nco Fune	- 4	195 Rit Severna	chie Hwy. Park MD21146			
	23. PART / Enter the diseases, or com shock, or heart failure. Lis	pilications that caused to t only one cause on each	he death. Do not h line.	enter the mod	te of dying, suc	h as cardiec or respi	ratory arrest,	Approximate interval Between			
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. 5 E P S I S S E CON P A RY DUE TO (OR AS A CONSEQUENCE OF):										
z	PINOMIANA										
ATIO	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING										
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF).								
AL CE	PART II. Other significent conditions of	contributing to death but	not resulting in	the underlying	cause given in	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS			
PHYSICIAN: MEDICA	EXTENSIVE METASTATIC PROSTATE										
N.											
SICU		OSPITAL:		THER:	ACE DF DEATN (Ch						
H	27. MANNER OF DEATN	26s. DATE OF INJURY (Month, Day, Year)	26b. TIME (OF 28c. INJU	JRY AT	8 Other (Specify) 28d. DESCRIBE NOW IF	NJURY OCCURE	:D			
BY F	1 Natural 5 Pending 2 Accident Investigation		INJUR	M 1 🗆 Y	ES 2 NO						
	3 Suicide a Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)										
COMPLETED		N: To the bast of my knowled On the basis of axamination a						use(s) end menner as stated.			
BE	Honry HE	ARROA HISAM	IDENT AL CE	NTER	29c. LICENSE NUR	723	29d. DATE SIG	SNED (Month, Day, Year)			
TO	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEATH	1 (ITEM 27) (TYPO. PY	ini) Foxfors	STREA	m ROAP	100	21236.			
	31. DATE FILED (MORITI, Day, Year) 1993	32. REGISTRAR'S SIGNATU	JRE Mindaill								

DHMH-18 Rev 1/89

TO BE COMPLETED BY FUNERAL DIRECTOR

18 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT/IF Ham

FOR STATE REGISTRAD 1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGISTRAR			ERTIFIC	SAIE	OF	DEAL	H	RI	EG. NO.			
1. DECEDENT'S NAME (First, Middle,		TO 01 1771 1						2. DATE OF D	EATH DAY	Y	YEAR	3. TIME OF DEATH
LAURA I	IANWAY (RONIN						March	1.	7	1993	М
213-38-7750	1 M 2300F	8. AGE (In yrs. la		IF UNDER 1 1	YEAR DAYS	HOURS	24 HRS.	7. DATE OF B (Month, Day			8. BIRTH Count	IPLACE (State or Foreign
9e. FACILITY NAME (If not institution,		91						8/12	/01			ryland
Lorien-Riversi		Home	1,	b. CITY, TO			ON OF DE	EATH			INTY OF D	
RESIDENCE OF DECEDEN	de Nursing	nome		Belo	camp	<u> </u>				H	arfo	rd
10e. STATE 10b. Co	DUNTY		10c. CITY,	TOWN OR	LOCATI	ON					\neg	10d. INSIDE CITY
Maryland	Harford		Abo	erde	≘n							LIMITS?
10e. STREET AND NUMBER					10t,	ZIP CODE				10g. CIT	IZEN OF V	VHAT COUNTRY?
712 Paul Drive	<u> </u>					210	001			U.	S.A.	
11. MARITAL STATUS		T EVER IN U.S. AI		13. WA	S DECE	NDENT O	F HISPAN	IIC ORIGIN? (Sp	ecify Yee			- American Indian, t, White, etc.
1 Never Merried 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE			1 [YES	2 KNO	Specify	r, Puerto Micen,	arc.)		Speci	
15. DECEDENT'S	EDUCATION		TOTAL INC.									nite
(Specify only highest	grade completed)	(0	ECEOENT'S US Give kind of wor a. Do NOT use i	k done dun retired.)	ing mos	t of worldn	9	16b. KIND	OF BUSI	NESS/IN	DUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5	+)	Homen					T	1			
17. FATHER'S NAME (First, Middle, Las			попел	aker		18 MOTH	ED'S NAI	ME (First, Middle,	home			
R. Percy Hanwa	v				- 1			n Eliza				
19e. INFORMANT'S NAME (Type/Print)		19	b. MAILING AI	DDRESS (S	Street en			loute Number, Ci				ży
Mrs. Marian Sa	ndlas	1						h, Hon				21116
20e. METHOO OF DISPOSITION 1 St Burlel 2 Cremetion 3		20b. PLACE	AND DATE OF	DISPOSITIO	ON (Nem	ne of	TVOL	OATE			City or To	
4 Donetion 5 Other (Specify)		Grove	Presk	r place) Ovter	ian	Cem	١.	3/20	Abe	rdee	n. M	aryland
21. BIGNATURE OF FUNERAL SERVICE	CE LICENSEE			22. NA	ME AND	ADDRES	S OF FAC	CILITY				
* Annu b	Wille	(NY.M	111	Tar	rin	g-Ca	rgo	Funera	l Ho	me,	P.A.	
officek, bi flaart fall	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between											
iMMEDIATE CAUSE (Final disease or condition	III.	/	1-	1	1.		-	/	4			Onset and Death
resulting in death)	a. OUE TO	(OR AS A CONSE	OUENCE OFI:	el	en	ree	SCU	lan		50	25	9
Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSE	GUENCE OF):	-							-	
CAUSE (Disease or injury	с											
that initiated events reaulting in death) LAST	DUE TO	(OR AS A CONSE	QUENCE OF):									
roading in death, EAST	d											
PART IL Other aignificant cond	litions contributing to	death but not i	reaulting in	the unde	rlying	cause g	iven in I	Part I. 24a.	WAS AN A	UTOPSY	24h.	WERE AUTOPSY FINDINGS
51 Tels +	Cano								PERFORM	EO?		AVAILABLE PRIOR TO COMPLETION DF CAUSE
								_ ''	YES 2	₹ NO		OF DEATH?
												1 YES 2 NO
25. WAS CASE REFERRED TO MEDICA EXAMINER?					28. PLA	CE OF DE	ATH (Che	ck only one)				
1 YES 2X NO	HOSPITAL:	ER/Outpatient 3	DOA 4	THER: Nursing	Home	5 🗆 Ree	idenca (B Other (Spec	olfy)			
27. MANNER OF OEATH	28e. DATE OF (Month, D		28b. TIME C	F 28	c. INJUI	RY AT		28d, DESCRIBE		JURY OC	CURED	
1 Netural 5 Pending 2 Accident Investigat		-,, 104.7	INOON		_	\$ 2 🗌	NO					
3 Suicide 8 Could no		F INJURY — At ho atc. (Specify)	me, term, stre	et, factory,	office			28f. LOCATION City or Tow	(Street and	d Number	or Aural A	oute Number,
4 Homicide determine	М							Oily or low	i, Gialey			
29e. CERTIFIER (Check only	PHYSICIAN: To the beet of	my knowledge, de	eth occurred a	it the time,	, date e	nd plece,	end due 1	to the cause(e)	end menn	or ee atat	ed.	1-1
one) 2 MEDICAL EXA	MINER: On the basis of e	samination end/or	Investigation, i	n my opini	lon, des	th occure	d at the t	lme, date end p	lace, end	due to th	e ceuse(s)	end manner ee steted.
296. SIGNATURE AND TITLE OF CERT	TIFIEN		0			29c. LICE	SE NUM	BER		29d. DAT	E SIGNED	(Mghih, Day, Year)
1/10	TX PO	RAC	1			14	391	クフフ		13	117	193
30 TAME AND ADDRESS OF PERSON	WHO COMPLETED CAUS	E OF OEATH (ITE	M 27) (Type, Pri	int)			- (1		-1	1	
TRIER J-L	diesti 1	20 [3	20 (NPO. HI	Sus	14	23	CH	42 U)	/	4	close	ward wis
31. DATE FILED (Month, Day, Year)	32. REGISTRA	R'S SIGNATURE						/		U	1	
	31. DATE FILED (Month, Day, Year) MAR 1 9 93 32. REGISTRAR'S SIGNATURE Sulvia Davidson—Randale											

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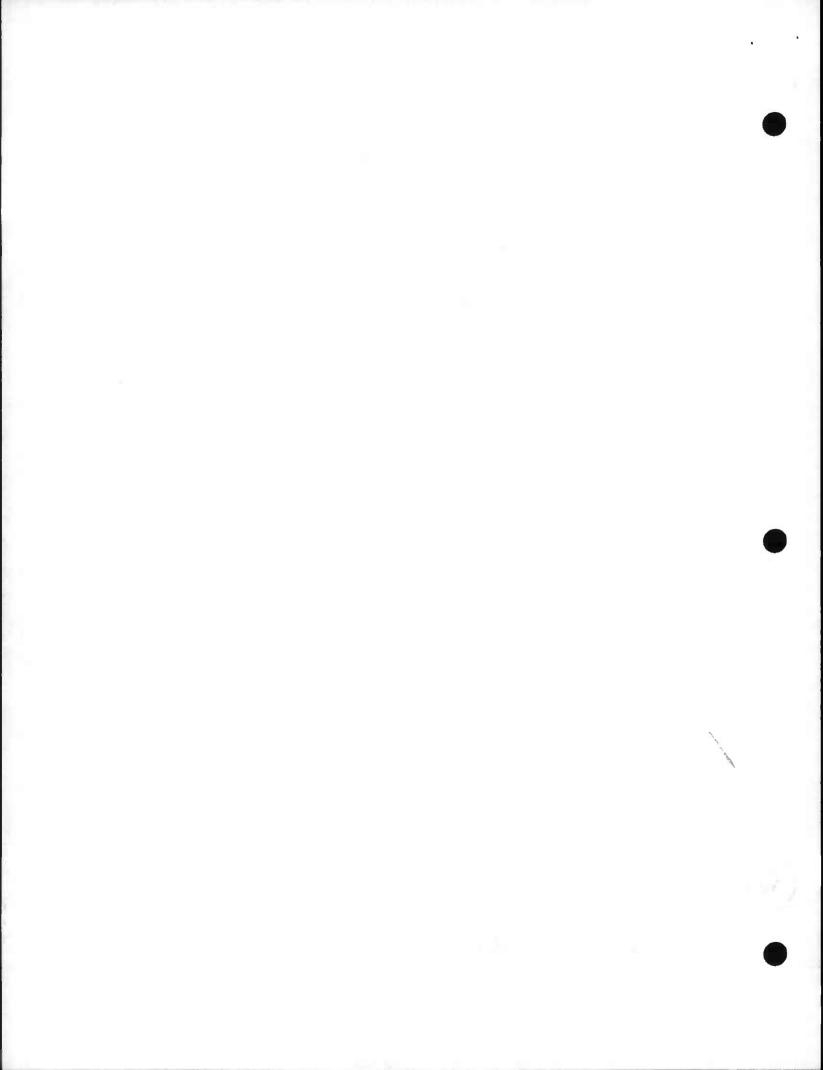
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OF VI	PHYSICIAN.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	OB ATTENDING DAVORDAN. The law requires that the death cartificate he executed within 24
5	a

TOTHE HIGH OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be law mater 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
DECEDENT'S NAME (First, Middle, Last)	A Cummines	2. DATE OF DEATH MONTH DAY

	1 - STATE REGISTRAR STATE CERTIFICATE OF DEATH REG. NO.
1	1. DECEDENT'S NAME (First, Middle, Lest) Patricia A Cummings 2. DATE OF DEATH MONTH 3 DAY 18 93 02:08 M
West Co	4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 F F GROWN BUSH DISTRIBUTE DAYS HOURS MIN. 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Morgh, Day, Year) Country) Mary (and)
OB	90. FACILITY NAME (If not institution, give strep cond number) 90. CITY, TOWN OR LOCATION/OF DEATH 90. COUNTY OF SEATH Navyland Baltimore 8a/falloce
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. CQUNTY 10d. MSIDE CITY
	MD Hartord, Have De Grace 11- YES 2 1 NO
FUNERAL	100. STREET AND NUMBER 2311 Sherwood Lane 101. ZIP CODE 21078 109. CITIZEN OF WHAT COUNTRY? US
B	11. MARITAL STATUS 1 Merried 2 Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 HO 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Inciden, Black, White, etc. 1 YES 2 NO Specify:
ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
APLE	Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker
COMPL	17. FATHER'S NAME (First, Middle, Last)
BE	196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
욘	Mr. Arthur L. Cummings 2311 Sherwood Lane, Havre de Grace, MD 21078
	20a. METHOD OF DISPOSITION 1 X Burlet 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of cemetary, crematory or other place) Bakers Cemetery 3/22 Aberdeen, Maryland
	4 Donation 5 Other (Specify) Bakers' Cemetery 3/22 Aberdeen, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
	Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF):
8	Samuration let and the sand th
CATI	if any, leading to immediate cause. Enter UNDERLYING
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in desth) LAST d
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS
MEDICAL	Dialetes Renal Failure Performed? Dialetes Renal Failure Performed? MARIABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Dialetes Renal Failure Performed? MARIABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AN.	
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 U-MO HOSPITAL: 1 Uniquelent 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)
PHYSICIAN:	27. MANNER OF DEATH 26. DATE OF INJURY (Month, Day, Year) (Month, Day
BY	1 Natural 5 Pending 2 Accident Investigation M 1 YES 2 NO
TED	3 Suicide 6 Could not be determined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28a. DLACE OF INJURY — At home, farm, street, factory, office City or Yown, State)
COMPLET	29e. CERTIFIER (Check only one) The CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated.
1 1	One) 2 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
) BE	Clayton Cherry MD Austhesialogy 20c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Your) 3-18-93
1	30. NAME AND ADDRESS OF PERSON WHO GOMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE
	MAR 1993 Julia Davidson-Bandall



THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be she within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

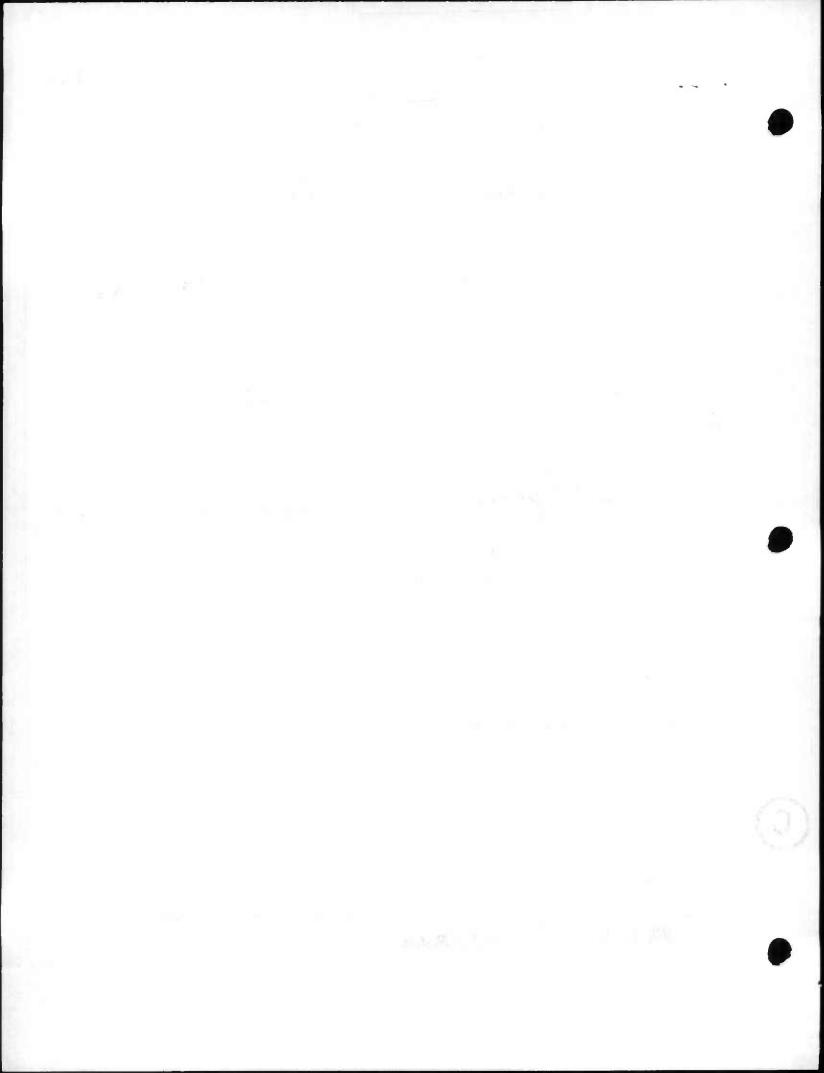
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3, TIME OF DEATH
	JOHN STEWAR	on c	ADVED			MONTH D/		
			ARVER			MARCH 16.	1993	7:05P M
- 1			(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLAGE (State or Econign
	212_14_1164	1 M 2 □ F S	1 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) April 9.	1911 Mar	my DOI will
	9a. FACILITY NAME (If not institution, give street			Oh CITY TOWN	OR LOCATION OF D			
l m				MD. CITY, TOWN	OH LOCATION OF DI	EATH	9c. COUNTY OF	DEATH
0	THE JOHNS HOPKI	INS HOSPITA	L. I	BAL	TIMORE C	ITY	RALT	IMORE CITY
5	RESIDENCE OF DECEDENT						DALL	THORE GITT
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY	Y, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?
5	Maryland Harfor	rd County	Be	el Air				1 TY YES 2 NO
_	10e. STREET AND NUMBER				f. ZIP CODE		100 CITIZEN OF	WHAT COUNTRY?
2	250 Cathamina Cha	a consta		1.0			200	
FUNERAL	350 Catherine Str	reet			210	14	U.S.A	•
5	H -	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED			NIC ORIGIN? (Specify Yes	or No- 14. RAC	E — American Indian,
	1 Never Married 2 Merried	IF YES, GIVE WAR OR			2 NO Specific	n, Puerto Rican, etc.)		ck, White, etc.
₽	3 Widowed 4 Divorced			1 1 123	2 IA NO Specif	у.	Spe	nite
	15. DECEDENT'S EDUCA	TION	16- DECEDENT'S	USUAL OCCUPATION	ON	THE WHIT OF THE	-	1100
	(Specify only highest grade co	ompleted)	(Give kind of w	vork done during mo	ost of working	160. KIND OF BUS	SINESS/INDUSTRY	
"		College (1-4 or 5+)						
- S	11 3)	Custome	er Relat	ions	Gas &	Electric	Co-
COMPL.	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden		
De notified at once. TO BE COM	Harry Swentzel	Carver			Clori		Stewar	<u>.</u>
BE	19a. INFORMANT'S NAME (Type/Print) NII 6							U .
1 1						Route Number, City or Town		
	Mrs. Margaret M. C	Carver	350 0	atherin	e Street	Bel Air.	Marylan	d 21014
2	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Remove	20	IN DI ACE AND DATEC	SE DISPOSITION (A)	non al	0475 300 10	CATION Chi T	Card-
must	4 Donation 5 Other (Specify)	al from State	metery, crematory or of	ther plece)	owr 3/1	8/93 Balt	- Am - m - B	Country of
6	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE JOSEPH W	Foster	22. NAME AL	ND ADDRESS OF FA	CILITY Foster	THOT'S	II
흍		_	. 100001	50 1	Wast Brown	og-was 8 14.	r mieral	nome
22	merceling	in Anales		Bel	Air Ma	adway & Wi ryland 210:	LLIAMS S	rreer
63	23. PART I. Enter the diseeses, Dr cor	molications that cause	ed the death. Do n	of enter the mo	de of duine our	h se serdies er mest		
9	ahock, or heert fellure. Lie	et only one ceuse on	eech line.	or other the the	de of dying, suc	ir es caldiec of reepi	retory strest,	Approximate interval Between
	IMMEDIATE CAUSE (Finel							Onset end Death
=	disesse or condition resulting in death)	Hennh	a Film					3 Weeks
E .	Treating in death)	OUD TO (OR AS	A CONSEQUENCE OF	T):				Dwee 2
or other traumatic event, the medical examiner								1- INVIDE
를 6	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury) CAUSE (Disease or Injury) Consider the cause of th						370410	
AT A	If sny, leading to immediate cause. Enter UNDERLYING	3016	- 1/	1 ~	*			
2 5	CAUSE (Diseese or Injury	10 Chen	A CONSEQUENCE OF	it Dus	ease			years
흥분	that initiated events	DUE TO (OH AS	A CONSEQUENCE OF	-):				
CERTIFI	resulting in deeth) LAST	Coronary	centery.	end per	pheral V	poscular of	18662	YEARS
3	PART II Oaker staniffered and III							
EDICAL	PART II. Other aignificant conditions	contributing to death	but not resulting i	n the underlyin	g ceuse given in	Part i. 24a. WAS AN PERFOR		b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
들일						1 N TES 2		COMPLETION OF CAUSE
								OF DEATH?
sho.						—		1 TYES 2 NO
Z Z								
ed, or item 23 shows PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Ch	eck only one)		
= 5	M -	Inpatient 2 ER/Ou	Ipatient 3 DOA	OTHER:	e 5 Residence	8 Other (Specify)		
	27. MANNER OF DEATH	28a. DATE OF INJURY				28d. DESCRIBE HOW II	N II IDV OCCUPED	
36	1 Metural 5 Pending	(Month, Day, Year)		URY WO	PRK?	200. DESCRIBE NOW II	NJOH! OCCORED	
mar BY	2 Accident Investigation				YES 2 NO			
<u>∞</u> 0	3 Suicide 6 Could not be	28e. PLACE OF INJUR building, atc. (Spe	Y — At home, farm, s	treet, factory, offic	•	261. LOCATION (Street a City or Town, State)	and Number or Rural	Route Number,
	4 Homicide determined		,			Only of Jown, Stelley		
MPORTANT: If Item D BE COMPLE	290. CERTIFIER 1 A CERTIFYING PHYSICIA	N. To the best of						
= 5	(Check only one)							
COMPL	2 MEDICAL EXAMINER:	On the besia of examinati	on and/or Investigation	n, in my opinion, d	leath occured at the	time, date and piece, an	d due to the cause(e) end manner ee stated.
E S	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	ABER I	29d, DATE SIGNE	O (Month, Day, Year)
<u> </u>	1/2 1/6/4/11.	100	- 1				D 0/	100
10	30 NAME AND ADDRESS OF STREET	-7001) L	NTERN		<u> </u>		3/16	193
. 18	30. NAME AND ADDRESS OF PERSON WHO							
A	PAUL VODONNEN	L, MD Je	itus Itopki	NS HOSP	TAL B	LTIMME	MD	
	31. DATE FILED (Month Day Year)	32. REGISTRAR'S SIG	NATURE					-
	MAK 1 8 93	Suha	Daydron- Ra	ndelle				I
	<u> </u>							

(WEIDN OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020	rSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should bit the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.	medical examiner must be notified at once.
MVBIDN OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPIN OF ATT COMB PHYSICIAN: The law requires that the death certificate be executed within 24 I	TO THE FUNETAL DIRECTOR After his certificate has been signed by the attending physician and completely filled in by the funerate the formal Hypiene prior to burial, cremation, or removal.	IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner gaust be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTMEN	T OF HEALTH AND E OF DEATH	MENTAL HYGIEN		08720	
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	MY YEAR	3. TIME OF DEATH	
	Bertha Rocelia Cr	<u>eighton</u>			03-13-93	YEAR	1402 pm	
	221 16 6372	6. AGE (In yrs. la		N 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Morath, Day, Year) 05-05-15	Cou	THPLACE (State or Foreign intry)	
OR	9a. FACILITY NAME (If not institution, give atreet Kent and Queen An			r, town on Location of D restertown M	EATH	9c. COUNTY OF	County	
띮	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CITY, TOWN	OR LOCATION			I was an area	
FUNERAL DIRECTOR	MD Kent		Rock I	lall			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
ERA	5050 Crosby Roa	d		101. ZIP CODE 109. CITIZEN OF W United			ed States	
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 I IF YES, GIVE WAR OR DATES 2	NO	WAS DECENDENT OF HISPA If yee, specify Cuben, Maxic 1 YES 2 NO Speci	an, Puarto Rican, stc.)			
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	mplated) (0	ECEDENT'S USUAL C Give kind of work done le. Do NOT use retired.)	CCUPATION during most of working	186. KIND OF BU	SINESS/INDUSTRY		
AP.	6th grade	, , , , , , , , , , , , , , , , , , , ,	housewi	fe	hom	emaker		
Ö	17. FATHER'S NAME (First, Middle, Last)				AME (First, Middle, Maiden	Surname)		
BE (Walter L Stigile			Sarah	F Fitzgera	ld		
10	19a. INFORMANT'S NAME (Type/Print)		9b. MAILING ADDRES	S (Street and Number or Rural	Route Number, City or Tow	n, State, Zip Code)		
-	Elizabeth	Boulter	20783 M	lercer Ave	, Rock Ha	.11, Md	. 21661	
	20e. METHOD OF DISPOSITION 1 🔀 Burlel 2 🗆 Cremation 3 🗀 Removal 4 🗀 Donation 5 🗀 Other (Specify)	from State cemetery, cr	ematory or other place, Ley Chap	el Cem.	3/17 Roc	cation — city or ck Hall	Town, State , Md . 21661	
	M Man K. H.	Henler	7	NAME AND ADDRESS OF F 106 Shamr Om Helfen	ock Rd Ch bein Fune			
	23. PART I. Enter the diseases, or copy abock, or haert fellure. Lies	plications that caused the d	leath. Do not ante	the mode of dying, suc	has cardiac of vesp	ratory artes, W		
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	Cardin		t			Interval Batween Onset and Death	
_		DUE TO (OR AS A CONSE	EQUENCE OF):					
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A CONSE						
CAT	cause. Enter UNDERLYING	CAD					i	
E	CAUSE (Disease or Injury that initiated eventa	DUE TO (OR AS A CONSE	EOUENCE OF):					
EB	resulting in death) LAST	HBP						
AL C	PART II. Other algnificant conditions of	ontributing to death but not	resulting in the up	nderiving cause given in	Part I. 24s. WAS AN	ALITOPSY 24	Ib. WERE AUTOPSY FINDINGS	
2	ASUN ¿C			enlled Do	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
	Sixes Helips	- lei		,	1 YES 2	□ NO	OF DEATH?	
2					_		1 YES 2 NO	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			28. PLACE OF DEATH (CI	neck only one)			
YSIG		OSPITAL: Inpatient 2 ER/Outpatient :	3 DOA 4 Nu	R: sing Home 5 - Residence	8 Other (Specify)			
표	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c, INJURY AT WORK?	28d. DESCRIBE HOW II	NJURY OCCURED		
BY	1 Natural 5 Pending 2 Accident Investigation		М	1 YES 2 NO				
ETED	3 Suicide a Could not be 4 Homicide determined	28e. PLACE OF INJURY — At he building, etc. (Specify)	ome, term, street, fac	ory, office	28t. LOCATION (Street a City or Town, State)	ind Number or Rural	l Route Number,	
COMPLETED		N: To the best of my knowledge, do On the besis of examination and/or					(e) and manner ea stated.	
	296 GIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU			D (Month, Day, Year)	
3 BE	plg (Amalul (4 5413		17238	19	12/21/4	12	
2	NAME AND ADDRESS OF PERSON WHO CO	DAPLETED CAUSE OF DEATH (ITE	EM 27) (Type, Print)	Wall, C	Un be have!	Med 2	21620	
1	TO DATE MARO (MONEY DE 91301)	32. REGISTRAR'S SIGNATURE						



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TO THE HOSPITAL OFFICEAL OFFICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

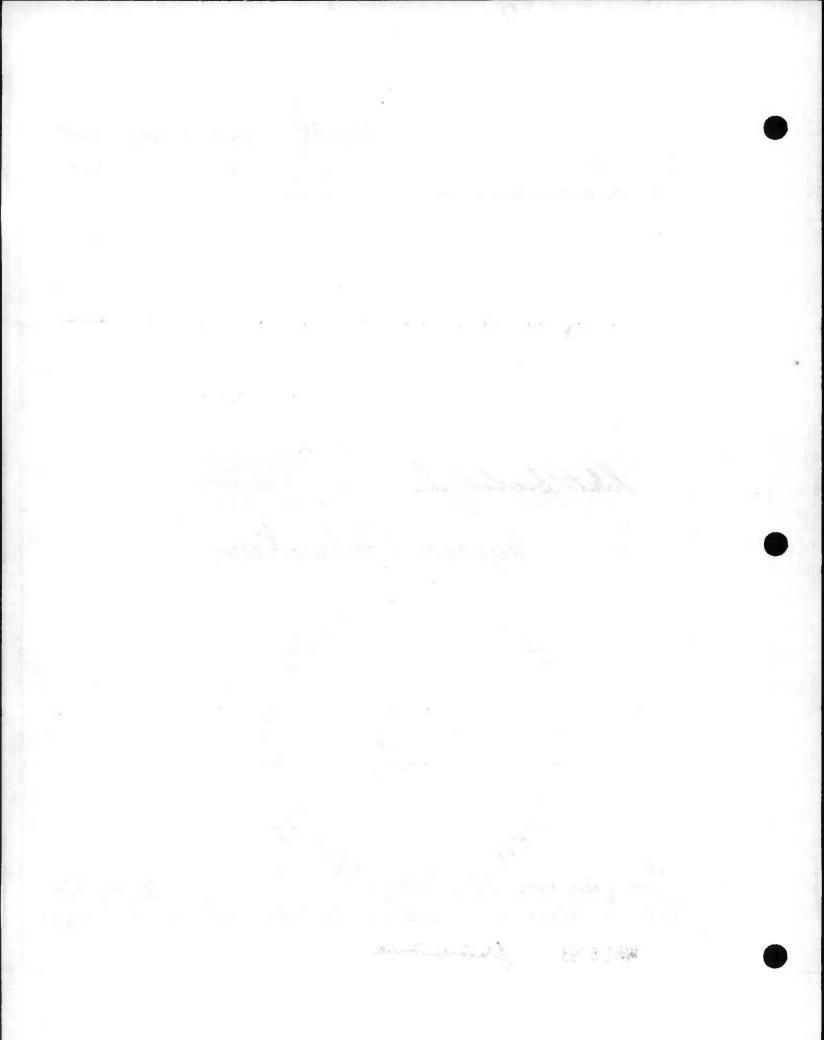
TO THE FUNERAL OFFICIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

32. REGISTRAR'S SIGNATURE

Suis Davidson-Randall

WAR1 8 '93



The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

The law requires that the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should least and Mental Hygiene prior to burial, cremation, or removal.

The 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

, P.O. BOX 68760,

FWITAL RECORDS	A The law requires that the d	shall has been signed by the	State Dept. of Health and Me.	ir item 23 shows any injur
=	(1	Statte the	O THE
SIS	TEN	CTOR:	after a	28 ls n
DIVISIO	TO THE HOSPITAL OR ATTEN	TO THE FUNERAL DIRECTOR:	be filed within 72 hours after an	IMPORTANT: If Item 28 is mi

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	4 DECEMBER NAME (C)					i di ti L	J. DE,	****	HEG. NO	-		
	1. DECEDENT'S NAME (First MAG)	6/5		В.		CHAP	NOCK	()	2. DATE OF DEATH DO NOTH	ž - (YEAR 3.	0500 M
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yr	rs. last birthday)	IF UNDER 1 Y		DER 24 HRS.	7. DATE OF BIRTH		8. BIRTHPL	ACE (State or Foreign
	229–70–2285	5	1 🗌 M 2 🔀 F	94	1 YRS.	MONTHS D	NYS HOURS	S MIN.	(Month, Day, Year) Sept. 23,	1898	Country)	rginia
	9a. FACILITY NAME (If not in	nstitution, give s	treet end number)			9b. CITY, TO	WN OR LOCA	TION OF DE			TY OF DEAT	
E	PENINSULA REGIONAL MEDICAL CENTER SALISBURY								COMIC			
1 K	RESIDENCE OF DEC	CEDENT										
DIRECTOR	10a. STATE	10b. COUNT			10c. CFT	Y, TOWN OR					10	d. INSIDE CITY
ā	Virginia	A A	ccomack			Tang	ner				1	LIMITS? YES 2 NO
4								10g. CITIZ		T COUNTRY?		
FUNERAL	Box 87 - Main St. Road 23440								U.S.	Α.		
5	11. MARITAL STATUS		12. WAS DECEDEN			13. WA	DECENDENT	OF HISPAN	IIC ORIGIN? (Specify Ver	or No-	14. RACE —	American Indian, fhite, etc.
IF MED CONTENTS OF THE PARTY OF												
			l									White
TED		EDENT'S EDU ly highest grade		160	a. DECEDENT'S (Give kind of t	work done duri	PATION of most of wo	rkina	16b. KIND OF BUS	SINESS/INDU	JSTRY	
COMPLET	Elementary/Secondary (0	0-12)	College (1-4 or 5		life. Do NOT us	ne retired.)						
§ A	Unknown		Unknown	1	Homemak	er			Home			
8	17. FATHER'S NAME (First, M	fiddle, Last)							ME (First, Middle, Malden	Sumeme)		
ш	Ranford Spe	ence					D	onna	Raleigh			
9 0	19a. INFORMANT'S NAME (7	Type/Print)			19b. MAJLING	ADDRESS (S	reet end Numi	ber or Rural R	Poute Number, City or Tow	n, State, Zip	Code)	
2	Charles Ray		Charnock	(Son)	P. C	. Box	72 –	Tangi	er, VA 23	440		
1	20a. METHOD OF DISPOSITE 1 DE Burlai 2 Crematic	on 3 🗆 Rem	oval from State	20b. PL	ACE AND DATE	OF DISPOSITION	N (Name of		DATE 20c. LO	CATION C	ity or Town,	State
1	4 Donation 5 Other			Swa	iin Chu	rch C	emeter	y-3/	16/93 Ta	ngier	, VA	
- 8	21. SIGNATURE OF FUNERA	IL SERVICE LI	ENSEE	1			E AND ADD			TT		
	Bradshaw & Sons Funeral Home Robert H. Bradshaw, Jr. 306 W. Main St Crisfield, MD 21817							21817				
	23. PART I. Enter the di	iseesea, or	complications the	t caused the	e deeth. Do r							Approximate
	anock, or he IMMEDIATE CAUSE (Fin		List only one car	ise on each	line.							Interval Between Onset and Death
	disease or condition		00-	11 6 1 7	- 1 1/-	:40	111	,	011110 -			Onset and Dead
	resulting in death)		DUE TO	(OR AS A CO	NSEQUENCE OF	77 <i>77</i>	1418/	- 1-1	AILUR F			
-												i
CERTIFICATION	Sequentially list conditi if any, leading to imme-	lona,	b. C DUE TO	(OR AS A CO	NSEQUENCE OF	F):						İ
¥	cause. Enter UNDERLY	ING	a A									ĺ
Ē	CAUSE (Disease or inju	ILY	DUE TO	(OR AS A CO	NSEQUENCE OF	F):						<u> </u>
E	resulting in death) LAS	T	4									
			u									
EDICAL	PART II. Other elgnifice	ent condition	e contributing to	deeth but r	not reaulting	n the unde	lying cause	given in i	Part I. 24a. WAS AN PERFOR			RE AUTOPSY FINDINGS
									1 TES 2		CC	MPLETION OF CAUSE
											1	YES 2 NO
≥ ::									_		1 "	
M	25. WAS CASE REFERRED TO	O MEDICAL					6. PLACE OF	DEATH (Che	ick only one)			
PHYSICIAN:	EXAMINER?		HOSPITAL:	ER/Outpatler	nt 3 DOA	OTHER:			8 Other (Specify)			
Ŧ	27. MANNER OF DEATH		28s. DATE OF	INJURY	28b. TIM	E OF 28	INJURY AT		28d. DESCRIBE HOW I	NJURY OCC	URED	
		Pending	(Month, E	lay, Year)	INJ	URY	WORK?	□NO				
BY	2 Cudelde	Investigation	28e, PLACE C	F INJURY — A	Al home, farm, r				28f. LOCATION (Street of	and Mumber	ar Bruss I Bount	Alumbar
8		Could not be determined	building,	etc. (Specify)		, , , , , , , , , , , , , , , , , , , ,	011100		City or Town, State)	ina ivamber (y nurei nout	e Numour,
ш	29e. CERTIFIER					_						
COMPLET	(Check only								to the cause(e) and man			
Ó	2 MEO	ICAL EXAMINE	R: On the basis of e	xamination en	d/or investigation	n, in my opin	on, death occ	cured at the	time, date and place, an	d due to the	cause(e) an	d manner se stated.
ш	29b. SIGNATURE AND TITLE	OF CERTIFIE	9	,	,		29c. Li	CENSE NUM	IBER	29d. DATE	SIGNED (M	onth, Day, Year)
00	Denny	2 /	the	mes	be		0	209	12	> -	7-1	2-97
일	30. NAME AND ADDRESS OF	F PERSON WH	O COMPLETED CAU	SE OF DEATH	(ITEM 27) (Type,							1
	Dennis Chod	nicki	MD. G	VINCU	+ LO	cust	Sts.	Sal	isbury, A	10	2180	1
	31. DATE FILED (Month, Day,			AR'S SIGNATU					7			
	MAR 1 6	'93	grine	Davidso	m-Aanda	00_						
			- 0				-					

for sure of the

permit. Pages 1, 2, 3 should

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2

Donald R.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Richter, M.D.

31. DATE FILED (ANTARY HE) 1 1993 32. BEGISTRARIS-SIGNATURE

e.	AL CHRECTOR And this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit		
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OR A	DIREC	SUMO.	tem.
PITAL	RAL	124	T. H. J
ESS.	FUNE	withi	DRTANT: If Item 25 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or att	D THE	be filed within 72 fours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPOF

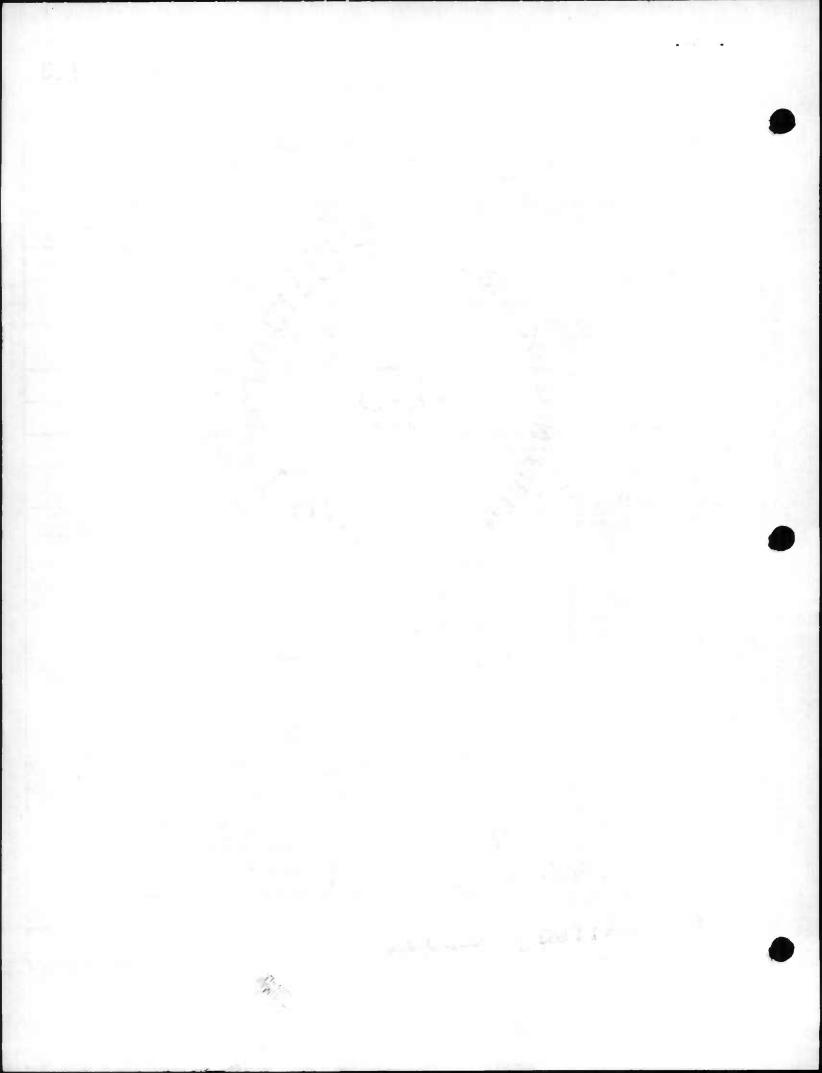
93 08723 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First Middle Last) 3. TIME OF DEATH YEAR Maud Viola CRAMER March 10, 1993 7:03 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Ybar) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 1 🗌 M 2 😡 F 90 YRS. 577-16-8390 Aug. 6, 1902 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH DIRECTOR Garrett County Memorial Hospital 0akland Garrett 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY WV Grant Bayard 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? P.O. Box 16 26707 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Married Specify: BY 1 YES 2 X NO Specify: 3 🔯 Widowed 4 🔲 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5 +) 8 Mail Sorter US Postal Service 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Robert George Hamilton Nora Culp BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 P.O. Box 148, Bayard, West Virginia Mrs. C. Alice Gaither 26707 20e. METHOD OF DISPOSITION
1 🔀 Burlal 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State ry, crematory of other place) Fairview Cemetery 3/12 Oakland, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY - Brille roundle K. Stewart Funeral Home 32 S. Second St., oakland, MD 21550 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between IMMEDIATE CAUSE (Finei Onset and Death disease or condition resulting in death) a. Respiratory arrest
OUE TO (OR AS A CONSEQUENCE OF) Sudden CERTIFICATION Days b. Bilateral pneumonia Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE Atherosclerotic cardiovascular disease 1 YES ZY NO OF DEATH? 1 - YES 2 - NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL:
1 (A Inpatient 2 - ER/Outpatient 3 - DOA OTHER: 1 YES 2 NO 4 - Nursi ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Ybar) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 4 Homicide 1 K CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the besia of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CONTINUES BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D30035

Rt#7 Box 1495 Oakland, MD 21550

Random

03-10-93



STATE OF MARYLANI	/ DEPARTMENT	OF HEALTH	AND	MENTAL	HYGIENE
	CERTIFICATE	OF DEAT	TH		REG. NO.

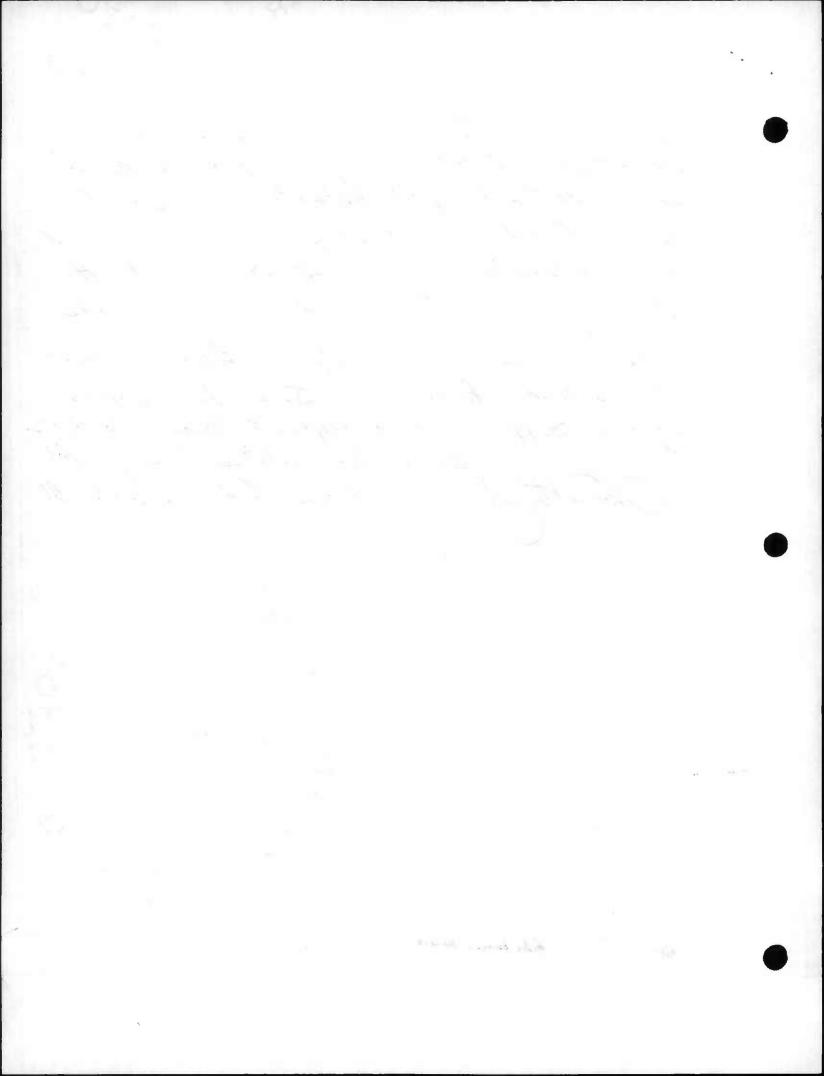
r		1 - FOR STATE REGISTRAR	STATE OF MARYLAND	O / DEPARTMENT OF CERTIFICATE OF		IENTAL HYGIEN REG. NO		
		1. DECEMENT'S HAME (First, Middle,	H. Douk	CAS		2. DATE OF DEATH MONTH D		3. TIME OF DEATH 6:30 P. M.
	1	4. SOCIAL SECURITY NUMBER 3/8-76-576	2 5. SEX 6. AGE (In yrs. 1 □ M 2 □ F	8 7 YRS. MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year)	05 1	BIRTHPLACE (State or Foreign Country)
z, 3 should	TOR	9a. FACILITY NAME (lighot institution,	my General +	4 - 1	MBIA	тн	9c. COUNTY HOL	OF DEATH O
. sages	DIRECTOR	RESIDENCE OF PECEDEN 100 STATE 100. CC		No. COTY TOWN OR LOCA	lik inis			10d. IHSIDE CITY LIMITS? 1 YES 2 PNO
ound-transit permit.	FUNERAL (10e. STREET AND HUMBER	32	,	21794	,	10g. CITIZEN	y of what country?
9	B	11. MARITAL STATUS 1 Newfor Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S.	MO If yes, a	ECEHDENT OF HISPANIC specify Cuban, Mexican, ES 2 NO Specify:	C ORIGIN? (Specify Ye, Puerto Rican, etc.)	9 or No- 14.	RACE — American Indian, Black, White, etc.
or use as	PLETED	15. DECEDENT'S (Specify only highest Elementary/Secondary (0-12)	S EDUCATION 16a. College (1-4 or 5+)	DECEDENT'S USUAL OCCUPAT (Give kind of work done during in life. Do NOT use retired.)	TION nost of working	16b. KIHD OF BU		innest
at once.	E COMPL	17. FATHER'S HAME (First, Middle, Las	Hotte/	1-1-	18. MOTHER'S HAM	E (First, Middle, Maiden	Sumama Ba	45e-Mah
be notified	TO B	19a. INFORMANT'S NAME (Type/Print)	sukes Jr.	196. MAILING ADDRESS (Street 27/8 At 32	4 6 4	Outo Number, City or Ton	m, State, Zip Co	21794
must		20s. SETHOD OF DISPOSITION 1 D Burlet 2 Cremation 3 C 4 Donation 5 Other (Specify)	Removal from State	CEAND DATE OF DISPOSITION (N. crematory or other place)	vame of backen	3ATE 20c. LO	CATION - City	s of Town, State
examin		21. SIGNATUBE OF FUNEHACIDETIVIC	Ald I	22. NAME	the 1	F. H. 6	ikst.	sinster And.
ation, or rem		23. PART I. Enter the disease shock, or heart fall IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. RESPIRATOR DUE TO (OR AS A CONS	line.		as cardiac or resp	iratory arrest	Approximate interval Between Onset and Death
burial, crem	NO	Sequentially list conditions,	DUE TO (OR AS A CONT. DUE TO (OR AS A CONT. DUE TO (OR AS A CONT.	•		FUSION	J	DAYS
ne prior to	RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. 13 RONCHO (DUE TO (OR AS A CONS	GENIC CA				NNKNONN
Mental jury,	AL CER		dd. ditions contributing to death but no	ot resulting in the underlyi	na cause given in P	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS
of Health an	MEDIC	CHRONIC OF	BRILLATION					MARABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
te Dept. o	SICIAN:	25. WAS CASE REFERRED TO MEDIC,			PLACE OF DEATH (Chec.	ck only one)		
or item	YSIC	EXAMINER? 1 YES 2 NO	HOSPITAL: Inpatient 2 ER/Outpatient	OTHER:	me 5 🗆 Residence 6	☐ Other (Specify)		
3.8	ВУ РНУ	27. MAHNER OF DEATH 1 Netural 5 Pending 2 Accident Investigat		INJURY W	JURY AT NA STORK? YES 2 □ HO	28d. DESCRIBE HOW I	NJURY OCCUR	ED
Tel 100		3 Suicide 6 Could no determine	28e. PLACE OF INJURY — At building, etc. (Specify)	t home, farm, street, factory, offi		281. LOCATION (Street City or Town, State)	end Number or I	Rural Route Number,
In 72 III	COMPLETED		PHYSICIAN: To the best of my knowledge, AMINER: On the basis of examination end/				nner as stated.	ause(e) and manner as stated.
	BE CC	29b. SIGNATURE AND TITLE OF CERT	TIFIER		29c. LICENSE HUMB	BER	29d. DATE SI	IGHED (Month, Day, Year)
E De	5	4-01	ON WHO COMPLETED CAUSE OF DEATH (I	ITEM 27) (Type, Print) # 1	07 CH	45 1 NG44		20/93 M.D.
		31. DATE FILED (Month, Day, Year)	MD 210 4U	.,				
		MAR 2 2 '93	Fishia Devideon-17	market a				

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be death with the Page 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be death with the Page 1, 2, 3 should be detached for use 2, 2 should be detached for use 3, 3 should be

	1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTM CERTIFIC	MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)	8. Dell			3. TIME OF DEATH 93 0655 M
	4. SOCIAL SECURITY NUMBER 2/4-03-7366		F UNDER 1 YEAR IF UNDER 24 HRS. ONTHS DAYS HOURS MIN.	7. DATE OF BIPTH (Month, Day Year) 1906	BIRTHPLACE (State or Foreign
OR	Sa. FACILITY NAME (If not institution, give atre	General Hospital 91	LIESTAINSTO		Y OF DEATH
DIRECTOR	RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY	10c. CITY, 1	DOWN OR LOCATION		10d, INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	(a) De	OFF. ZIP CODE	10g. CITIZE	1 VES 2 NO
FUNERAL		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 PRO		NIC ORIGIN? (Specify Yes or No.— 1	I. RACE — American Indian, Black, White, atc.
B	1 Nover Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	If yes, specify Cuber, Maxic 1 TYES 2 THO Speci		White
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+) (Give kind of work life. Do NOT use re	done during most of working	16b. KIND OF BUSINESS/INDUS	6/06101
COMP	17. FATHER'S NAME (First, Middle, Last)	- Dales	18. MOTHER'S N.	AME (First, Middle, Maiden Surname)	over oc.
BE	19a. INEORMANT'S NAME (Typo/Print)	R Reese		Route Number, City or Town, State, Zip C	aples
10	Julia C. Se	100 28514 20b. PLACE AND DATE OF C	Kenptown	RD. Danascus	/ / 00872 ry or Town, State
	1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	ral from State confetery, crematory or other	menuich Cade	15/22 Finksbu	15 M.
	· Hon In	t 1	22. NAME AND ADDRESS OF F	L. H. West	sinster Ad.
	shock, or heert failure. L	implications that caused the death. Do not all only one cause on each line.	enter the mode of dying, su	ch as cardiac or respiratory arres	interval Between
	iMMEDIATE CAUSE (Finel disease or condition resulting in death)	Cardia	c arra	al	Onset and Death Hozek
Z	Sequentially list conditions,	a cute y	ryo caro	Lial	day
CATIC	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONSEQUENCE OF):	o inst	anotion	
CERTIFICATION	that initiated events resulting in death) LAST	OUE TO (OR AS A CONSEQUENCE OF):			
¥.	PART II. Other significant conditions	contributing to death but not resulting in t	the underlying cause given in	Part 1. 24s. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
MEDIC				1 YES 2 NO	COMPLETION OF CAUSE DF DEATH?
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (C	Pook ont one)	
SICI	EXAMINER?		THER: Nursing Home 5 Residence		
	27. MANNER OF OEATH 1 Netural 5 Pending	28a. OATE OF INJURY (Month, Day, Year) 28b. TIME O	PF 28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCU	REO
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At home, farm, stre- building, etc. (Specify)	at, factory, office	281. LOCATION (Street and Number of City or Town, State)	Rural Route Number,
COMPLET	29a. CERTIFIER (Check only	IAN: To the best of my knowledge, death occurred a			
	one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	On the basis of examination and/or investigation, i			
TO BE	Ephraim	Barzags 54	1 La DIL	1992 D 3	BIGNEO (Month, Day, Year) 5 - 20 - 9 3
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Pri	- /	IN doop , V	nd 21776
	MAR 2 2 93	12. REDISTRAR'S SIGN TURE		,	



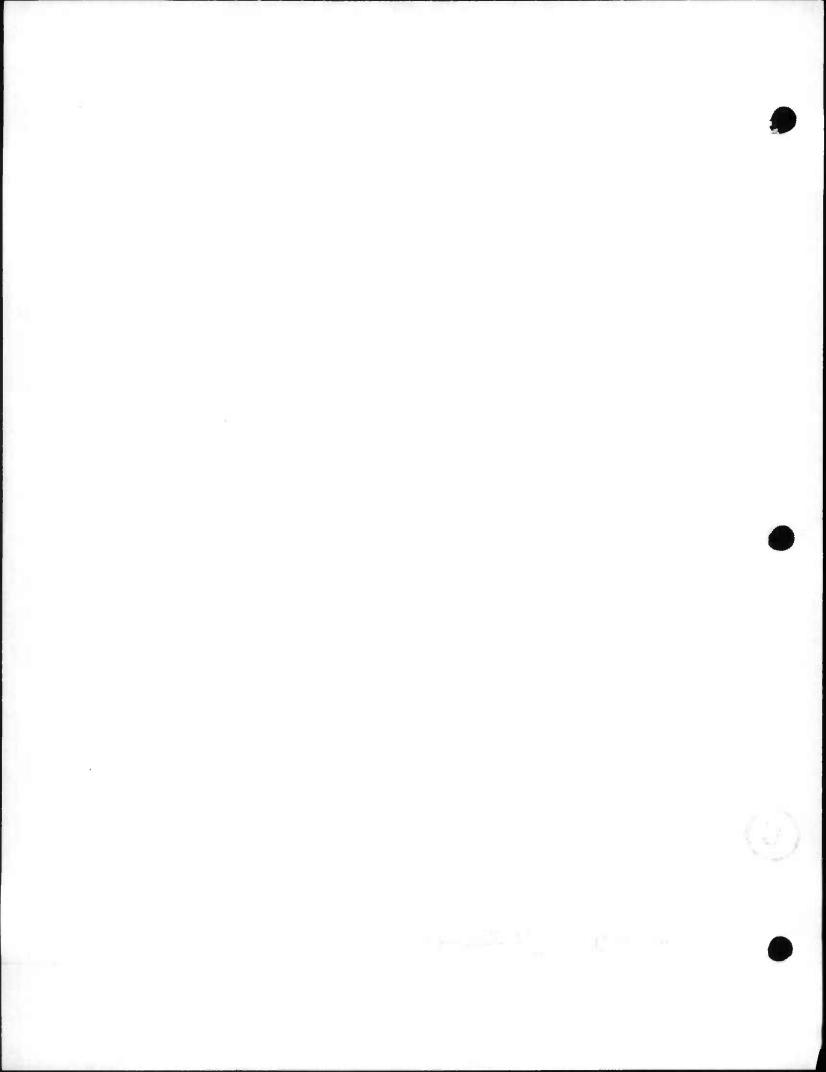
BALTIMORE, MARYLAND 21215-0020

VISION OF VITAL RECORDS, P.O. BOX 68760, LOWERT ENDING PHYSICIAN: The law requires that the death certificate be exe

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מינים לו היינים ביינים	TO THE FLOW DIR FIGHT. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to	be filed within a media mark death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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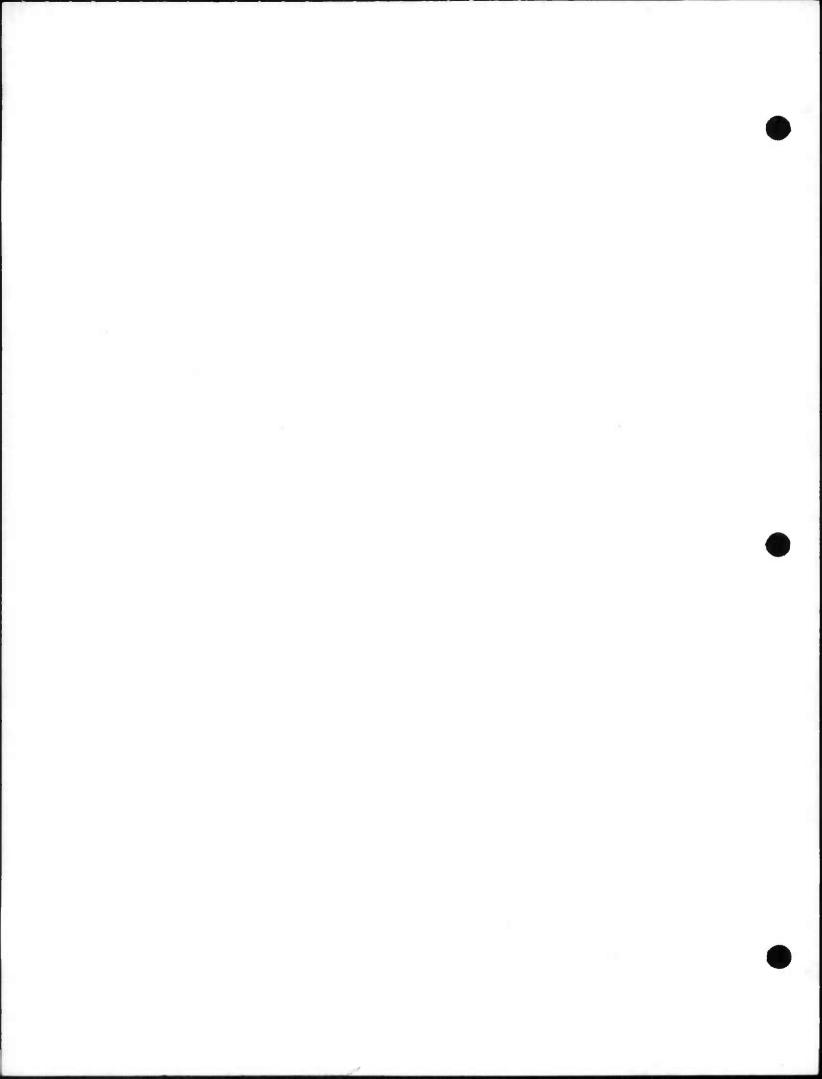
STATE	0F	MARYLAND	/ DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
			ERTIFICATE					REG. NO.

	1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTAL HYGIEN		00120
	1. DECEOENT'S NAME (First, Middle, Lest) MARGARET	r G	Do	MGL	ASS	2. DATE OF DEATH		3. TIME OF DEATH
				IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	9.3 0. BIRT	HPLACE (State or Foreign
	0.00	□ M 2 🔀 F	79 YRS.	ONTHS DAYS	HOURS MIN.	Feb. 8, 19	Cour	hington,DC
Œ	9e. FACILITY NAME (If not institution, give street				R LOCATION OF DE	ATH	9c. COUNTY OF	DEATH
CTO	Bethesda Nursing Co	enter		Chevy C	hase		Montgo	mery
DIRECTOR	D.C. N/A			TOWN OR LOCAT				10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER		was	hington 101.	ZIP CODE		10g. CITIZEN OF	1 X YES 2 □ NO WHAT COUNTRY?
FUNERAL	1610 Crittenden St			2	0011			States
	11. MARITAL STATUS 12 1 Never Married 2 X Married	2. WAS DECEDENT EVER IN FORCES? 1 YES	2 X NO	If yes, spe	cify Cuban, Mexican	IC ORIGIN? (Specify Yee i, Puerlo Rican, atc.)		CE — American Indian, ck, White, etc.
ВУ	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA	TES	1 🗆 YES	2 NO Specify:		Spe	offy: Black
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	1ON mpleted)	(Give kind of wo	rk done during mos	N t of working	16b. KIND OF BUS	BINESS/INDUSTRY	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Teacher			Public	Cabaala	
NO.	17. FATHER'S NAME (First, Middle, Last)		reacher		18. MOTHER'S NAM	ME (First, Middle, Maiden		
BE (Richard Gantt			-		th C. Smit		
5	190. INFORMANT'S NAME (Type/Print) Alvin G. Douglass,	Sr				oute Number, City or Town		
	20a7 METHOD OF DISPOSITION	205	PLACEANDDATEOF			.W., Washi	ngton, I	O.C. 20011
	1 Donation 5 Other (Specify)	from State come	etery, crematory or other Lincol	er placa!		/10/93 Bre		
	21. SIGNATURE OF PURITAL SERVICE LICENS	SEE	-		D ADDRESS OF FAC	al Service		
	fran (100)	(sur		7400 (Georgia A	Ave. N.W	Washing	ton, D.C.
	28 PART I. Enter the diseases, or com shock, or heart failure. List	t only one cause on ea	ch line.	t enter the mod	la of dying, auch	as cardiac or reapi	ratory arrest,	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition	anut	CONSEQUENCE OF:	of Li	Pupa			Onset and Death
	resulting in death) a	DUE TO OR AS A	CONSEQUENCE OF):	a ju	2 0 1	1		Zapa
O	Sequantially list conditions, b	Chron	uch	andl	fact	url		3 yrs
CATI	If any, leading to immediate cause. Enter UNDERLYING	OUE TO (ON AS A T	CONSEQUENCE OF);		0			
TE	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION	d							
A	PART II. Other significant conditions of	ontributing to death bu	t not reaulting in	tha underlying	cause given in F	Part I. 24s. WAS AN . PERFOR		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
Sign	generalized	arter	rocles	1910		t YES 2	-	COMPLETION OF CAUSE OF DEATH?
×.						_		1 TYES 2 NO
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PLJ	ICE OF DEATH (Chec	ck only one)		
YSIG	t □ YES 2 NO 1	OSPITAL: Inputient 2 ER/Output	flent 3 DOA 4		5 Residence 8	Other (Specify)		
	27. MANNER OF DEATH 1 Natural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME (Y WOR		28d. DEŞCRIBE HOW IN	JURY OCCURED	
) BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY	At home, lerm, stre			281. LOCATION (Street e	nd Number or Rural	Route Number,
COMPLETED	4 Homicide determined	building, etc. (Specif	у)			City or Town, State)		
APLE		N: To the best of my knowle						
S	2 MEDICAL EXAMINER: 0	n the besie of examination	end/or investigation,	in my opinion, de	ath occured at the ti	ime, date and place, and	due to the ceuse(e) end menner ee stated.
BE	and Signaturie and Title of CERTIFIER	Sena	1/00/10	ma	29c LICENSE NUME			(Month, Day, Year) -93
2	30. NAME AND ADDRESS OF PERSON WHO CO	DMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, Pr	rint)	- / - / 2	-/		-/3
		U						
	MAR 08 93	39. REGISTRAR'S SIGNAT	Mardell					
	0 00	/	•					



BALTIMORE, MARYLAND 21215-0020	YSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should th the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24	TO THE FLINEMAL MRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTME	NT OF HEALTH ANI TE OF DEATH		GIENE		J I Lia ?
	1. DECEDENT'S NAME (First, Middle, Last)			TE OF BEATTI	2. DATE OF DE	EATH		3. TIME OF DEATH
	Barbara	Kardos	Donohoe		March	12, 19	YEAR QQQ	6:40 A M
	4. SOCIAL SECURITY NUMBER	37	yrs. last birthday) IF UN	DER 1 YEAR IF UNDER 24 HRS	7. DATE OF BE	RTH	8. BIRTH	PLACE (State or Foreign
	189-20-1733 9e. FACILITY NAME (If not institution, give s	1 □ M 2 ♣ F 6.		IS DAYS HOURS MIN	June 1	0,1927	Countr	Taylor, PA
DIRECTOR	8238 Buckspark I			Potomac			ntgon	
E	10a. STATE 10b. COUNTY	r	10c. CITY, TOW	N OR LOCATION				10d. INSIDE CITY
5	MD Mont	tgomery	Poto	mac				LIMITS?
FUNERAL	10e. STREET AND NUMBER			10f. ZIP CODE		10g. CIT	IZEN OF V	VHAT COUNTRY?
9	8238 Buckspark]			2085	4		USA	
5	11. MARITAL STATUS 1 Never Married 2 Monthled	12. WAS DECEDENT EVER IN U FORCES? 1 YES	2 NO	3. WAS OECENDENT OF HIS If yes, specify Cuban, Mex	PANIC ORIGIN? (Specien, Puerto Rican	cify Yes or No-	14. RACE Black	— American Indien, c, White, etc.
à	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	ES	1 YES 2 NO Spe		vic.,	Speci	'y :
	15. DECEOENT'S EDUC	CATION	16a. DECEOENT'S USUAL	OCCUPATION	165 KIND	OF BUSINESS/INC	HETDY	White
E.	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work do life. Do NOT use retire	ne during most of working	1000 10110	Or Boomesomin	, O 3 1 M 1	
鱼		4	Nurse			ledicine		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S	NAME (First, Middle,			
BE	George Kardos				ra Belen			
10	Dr. Robert F. Do	onohoe	19b. MAILING ADDR 8238 Bu	ess (Street and Number or Aut Ckspark La.	W., Poto	y or Rown, State, Zip		354
	20 METHOD OF DISPOSITION	206. F	PLACE AND DATE OF DISP	OSITION (Name of	DATE	20c. LOCATION —	City or To	un State
	1 ⚠ Buriel 2 ☐ Cremation 3 ☐ Remo	oval from State cemet	ery cremetory or other ola	ven Cemetery				100,000
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		2. NAME AND ADDRESS OF	FACILITY		OPLII	ig, iii
:	muchale	Cha Da		Joseph Gawle		-		0.004
	23. PART I. Enter the diseases, or o	complications that caused t	the death. Do not en	5130 Wiscons	in Ave, N	W , Washi	ngto	Approximata
	shock, or heart failure. I	List only one cause on eac	ch line.	, , ,			,	Interval Between Onset and Death
- 1		Metect	ti-	or einger				100000000000000000000000000000000000000
	resorting in death)	DUE TO (OR AS A C	CONSEQUENCE OF):	FEINDMA				+ ew mas
Z	Sequentially list conditions,	DUE TO (OR AS A C	celle	arcinoma	0+ L	ung		few mas
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A C	CONSEQUENCE OF):		,			
S	CAUSE (Disease or Injury	DUE TO (OR AS A C	ONSEQUENCE OF:					
Ē	that initiated events resulting in death) LAST		,					į į
		1.						
AL N	PART II. Other significant conditions	s contributing to death but	not resulting in the	underlying cause given		WAS AN AUTOPSY PERFORMED?	24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
8					1	YES 2 NO		COMPLETION OF CAUSE OF DEATH?
M								1 - YES 2 - NO
ä								
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ОТН	26. PLACE OF DEATH (Check only one)			
¥ ∥	1 YES 2 NO 27. MANNER OF DEATH	28e. DATE OF INJURY	lent 3 DOA 4 D	lursing Home 5 X Residence				
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE	HOW INJURY OC	CURED	
à l	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY -	- At home, farm, street, f		281 LOCATION	/Streat and Number	or Over 0	hute Musebas
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined 28e. PLACE OF INJURY — At home, farm, street, factory, office 5 building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office 5 building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office 5 city or lown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office 6 city or lown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office 6 city or lown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office 6 city or lown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office 6 city or lown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office 6 city or lown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office 6 city or lown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office 6 city or lown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office 6 city or lown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office 6 city or lown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office 6 city or lown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office 6 city or lown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office 6 city or lown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office 6 city or lown, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office 6 city or lown, state 6 city or lown, state 7 city or lown, state 7 city or lown, state 7 city or lown, state 7 city or lown, state 8 city or lown, sta						oote Warnoor,	
ן ב	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my knowled	ige, death occurred at th	e time, date and place, and d	ue to the cause(e)	and manner se stat	ad	
\ <u>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</u>	one) 2 MEDICAL EXAMINER	R: On the basis of examination e	end/or investigation, in m	y opinion, death occured at t	he time, date end p	lace, end due to th	e cause(e)	end manner ee stated.
	296. SIGNATURE AND TITLE OF CERTIFIER			29c, LICENSE N				(Month, Day, Year)
H	6. Langer	1 Rel	M.D.	no	011	▶ 2	110	102
유	30. NAME AND ADDRESS OF PERSON WHO			1002	011		112	17.5
	G. Lennard Gold	, M.D., 2415	Musgrove R	d., Silver S	pring, M	D 2090	4	
	31. OATE FILED (Month, Day, Year)	32. RECISTRAR'S SIGNAT	URE					
	MAR 16 '93	grelia Davidso	A Handell					



		FOR
4		STATE
	-	DECICTOAD

#4, FilmG699 5/12/93 kam
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

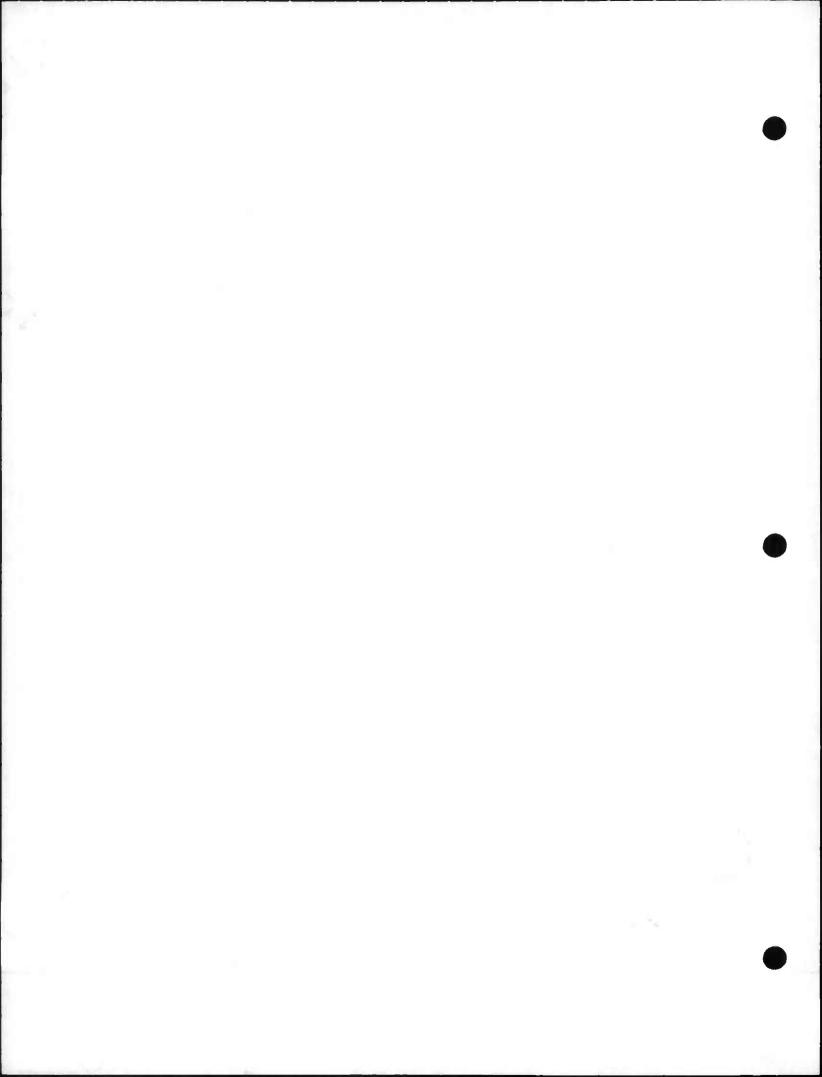
		REGISTRAR		CEI	ATTIFIC:	AIE OF	DEATH	F	REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Lest)	Davids	200				2. DATE OF MONTH	DEATH	- a	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	7	(In yrs. last b	oirthday) IF	UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF	HIDTH		3 0400 A M BIRTHPLACE (State or Foreign
		578-65-1498	1 M 2		4101	NTHS DAYS	HOURS MIN.	9-20-	1912		Country) Zirqinia
should		9a. FACILITY NAME (If not institution, give	street and number)			CITY, TOWN	OR LOCATION OF DE		1712	9c. COUNTY	
60	8	Suburban Hospital	L			Betheso		Montgomery			30 -50
1, 2,	DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT				Tionegalery				Calciy	
Page	뿔					OWN OR LOCA					10d. INSIDE CITY LIMITS?
								1 TYES XX NO			
							OF WHAT COUNTRY?				
020 physician. burial-transit	벌	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN II S ADME	ED		20705				d States
D20 physia burial		1 Never Married 2 Married	FORCES? 1 YES	2 K MO		If yes, sp	CENDENT OF HISPAN	n, Puerto Ricar	n, etc.)		RACE — American Indian, Black, White, atc.
215-0020 attending physician se as the burial-tra	ВУ	3 XXIdowed 4 Divorced	IF TES, GIVE WAR ON I	DATES		I I TES	3 2 XIO Specify	r			Specify: White
21215-0020 If or attending physic for use as the burial	ETED	15. DECEDENT'S EDU (Specify only highest grad	ICATION completed)			JAL OCCUPATE done during me		16b. KIN	OF BUSI	NESS/INDUST	RY
		Elementary/Secondary (0-12)	College (1-4 or 5+)	life. De	o NOT use ret	tired.)	at or working				
ND hospit ached	COMPL	12 years		Home	maker						
YLAND 2 by the hospital be detached to at once.	8	17. FATHER'S NAME (First, Middle, Last) William Tiffon	Voorte				18. MOTHER'S NAI			umame)	
RY ed by used by as a second by	H	19a. INFORMANT'S NAME (Type/Print)	Koontz				Nellie				
MARYLAND 2- retained by the hospital of 5 should be detached for notified at once.	2	Nancy D. Hutchir	15		MAILING ADD Same a		and Number or Rural F	loute Number, (City or Town,	State, Zip Cod)
		20g METHOD OF DISPOSITION				ISPOSITION (N	-mad		20- 1004	7:00	
ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be		1 X Furial 2 Cremation 3 Ran 4 Donation 5 Other (Specify)	ioval from Stata	metery, crema	tory or other p	Cemete	neor 3/	17/93			or Town, State Maryland
Page 6 al directo		21. SIGNATURE OF FUNERAL SERVICE LI				22. NAME A	ND ADDRESS OF FAC	31 ITV			
BALTIMORE, after death. Page 6 may be y the funeral director, page noval. cal examiner must be		V Sugar	(Any)	dit		Donal	d V. Bor	gwardt	Fune	eral H	ome, P.A.
B/ i after of by the emoval.		23. PART i. Enter the diseeses, pr	complications that cause	d the deat	h. Do not e	4400	Powder M	ıll Rd	. Bel	tsvil	ie, Md. 20705
hours after d in by th or remove		enock, or heart fellure.	List only one cause on	eech line.	ii. Do libt e	onter the the	rue Di uying, suci	1 es cerdiec	or reepira	itory arrest,	interval Between
24 jille jon,		iMMEDIATE CAUSE (Finei disease or condition	A 10 0	/	1/2	/	. 1	. 10	in t	-	Onset and Death
at the state of th		resulting in death)	o. Ac ute Co	A CONSEQUE	ENCE OF:	ocu ja	N HC	cide	YEI	-	Sudden
	_		ARTER	2115	C / =	= 705	· ·				11006
8 " o =	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUE	ENCE OF):	200	()				700
BOX cate be e shysiclan e prior to	3	cause. Enter UNDERLYING CAUSE (Disease or Injury	c. 0196, DUE TO (OR AS	41	1/	nell	1 tus	•			years
P.O. E th certifica tending phy al Hygiene or other	1	thet initiated events resulting in deeth) LAST		4		4					
- 5 5 6	H		a Hype	rte	171	00					yea-
DS the the ding was a second		PART II. Other significent condition	na contributing to deeth	but not rea	uiting in th	ne underlyin	g ceuee given in	Part I. 24s	. WAS AN AL		24b. WERE AUTOPSY FINDINGS
- 5 C C S	EDICAL							10	PERFORM	000	AVAILABLE PRIOR TO COMPLETION OF CAUSE
C se se se	ME									2 225	OF DEATH?
AL RE e law reques has been of H								_			
VITAL AN: The law tificate has l e State Dept	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				ACE OF DEATH (Che	ck only one)			
F VIT, SICIAN: Th certificate the State I, or iten	\Si	1 🗆 YES 2 🗷 NO	1 Inpetient 2 ER/Out	tpetient 3 🗆		THER: Nursing Hom	e 5 🗆 Raaldence	8 🗆 Other (Sp	ecify)		
OF PHYSIC this ce with th	РНУ	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	1	86. TIME OF	28c. INJ WC	URY AT	28d. DESCRI	BE HOW INJ	URY OCCURE	D
ON OF DING PHYS After this of death with s marked,	BY	1 Netural 5 Pending 2 Accident Investigation					YES 2- NO				
	E	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, atc. (Spe	Y — At home ecify)	, lerm, atreet	t, factory, offic	•	281. LOCATIO City or To	N (Street and wn, State)	d Number or R	ural Route Number,
DIVIS DIRECTOR DONES after Item 28		AN- OCCUPIED									
E 42 =	MP		ICIAN: To the best of my know								
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II	COMPLET	2 MEDICAL EXAMINI	ER: On the beels of examination	on and/or inve	eatigation, in	my opinion, d	leath occured at the	time, data and	place, and	dua to the ca	see(s) and manner as stated.
TO THE HOSPI TO THE FUNER OF filed within	BE	296 SIDMATURE AND TITLE OF CERTIFIE					29c. LICENSE NUM	BER	1	29d. DATE SIG	ENED (Month, Day, Year)
D 0 9 M	2	30. NAME AND ADDRESS OF PERSON WI-	O COMPLETED OCCUPA	CATU ATT	TR /T		231.	319		13/	15193
		Love to 5 A BI						>	11	/	100
		31. DATE FILED (Month, Day, Year)	32, REGISTRAR'S SIGN		MIZ	cons	inAve	20	thes	da	ms
		MAR 76 102	Lelia Karista	, X2	. 00						

1 - STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 6870	7
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	í	1. DECEDENT'S NAME (First,										2. DAT	E OF DEATH	IV.	YEAR	3. TIME OF	DEATH
	1		VIOL	ET DA	VIS							Ма				5:00	p w
	- 1	4. SOCIAL SECURITY NUMB		5. SEX		'In yrs. lest bir	MON	UNDER 1	YEAR	IF UNDER	24 HRS.	(Mor	E OF BIRTH ith, Day, Year)		Country	LACE (State	-
		580-10-894		1 M 2/(3/F	5:	3	YRS.					04	-10-1	939	Brit	ish	Colu
	- 1	9a. FACILITY NAME (If not in:									ON OF DE			177	NTY OF DE		
Ę	HO IS	2102 Rando	lph	Road, #	203		Silver Sprin							MO	NTGC	MERY	
l i	DIME	10a. STATE	10b. COUNT	γ		10c. CITY, TOWN OR LOCATION										10d. INSIDE	СІТҮ
		Maryland	Мо	ntgomer	У		Silv	<i>j</i> er	S	orin	ıg					1 YES 2	
1 4	₫	10e. STREET AND NUMBER	l so le	Dand H	202				101	ZIP COD	903			10g. CITI		HAT COUNTY	RY?
FINED	Z	2102 Rando	тБи											L	US		
	- 10	1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 NO	D	H 3	es, spi	ecity Cube	in, Mexica	n, Puerto	IN? (Specify Yes Rican, etc.)	or No-	Black,	- American White, etc.	Indian,
×		3 Widowed 4 XDivo	rced	11 123, GIVE V	win on or	1169		ינ] TES	225,280	Specify				Specify	" в1	ack
ETEN		15. DECI (Specify only	EDENT'S EDU	CATION completed)		(Give I	DENT'S USU	done dur			na	16	b. KINO OF BU	INESS/INC	USTRY		
in 2	ן י	Elementary/Secondary (0-	-12)	College (1-4 or 5	+)		NOT use ret		C ()	2			Store				
IdMo	\$	17. FATHER'S NAME (First, MI	(ddla Last)			56	ales	Jer	501	_	HERIO NA		Middle, Maiden		=		
L C		Unknown	2010, 2201,										lette	Sumame)			
a a		19a. INFORMANT'S NAME (7)	/pe/Print)			19b. M	AILING ADD	RESS (S	Street a				nber, City or Tow	1, Stutu, Zip	Code)	209	0.2
TO R	-	Leonard Da	vis	(son)									203,				
		20a. METHOD OF DISPOSITI	ON n 3 🗆 Rem	oval from State	20b.	PLACE AND	DATE OF DI	SPOSITI	ON (Na	me ot		DA			City or Tow		
		4 Donation 5 Other	(Specify)		Ğ	ate	of H					-	17 Si	.ver	Spr	ing,	MD
		21. SIGNATURE OF PONERAL	1 SERVICE U	CENSEE	m - 0	Ala					SS OF FAC		AL HON	Œ.	P.A.		
	4	un,	K	1/10	111	de	4	R	OCK	VIL	LE,	MD	2085	0			
		23. PART I. Enter the dishock, or he	seeses, or eart fallure.	List only one cet	use on ea	ech iine.					ing, suct	as ca	rdiac or respi	ratory arr	est,		ximate al Between
		IMMEDIATE CAUSE (Fin	al	Canc	er c	f St	omac	h	40	CH							and Death
		resulting in death)	→	a. C7\NCC	400.40	Ol	>1 ~	3-2		70							
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CERTIFICATION	2	If any, leading to immediate															
S.	5	LAUSE IDISEASE OF INIUTY															
H		that initiated events resulting in death) LAST		CONSEQUE	ONSEQUENCE OF);												
l lij			-	d												+	
	- 14	PART II. Other aignificat	nt condition	a contributing to	deeth be	ut not resu	iting in th	e unde	rlying	ceuse (given in i	Part i.	24a. WAS AN PERFOR			WERE AUTOP	
MEDICAL	3											_	1 YES 2			COMPLETION OF DEATH?	
M	ž I															1 YES 2	□ NO
AN: MEDICAL C	į	25. WAS CASE REFERRED TO	14501011														
YSICIAN		EXAMINER?	MEDICAL	HOSPITAL:] Envo			HER:			EATH (Che						
PHYSICIAN		27. MANNER OF DEATH		1 Inpetient 2 28a. DATE OF	INJURY		8b. TIME OF	_	ic. INJI	URY AT	esidence		er (Specify) SCRIBE HOW II	UURY OC	CURED		
ВУР	100		Pending rivestigation	(Month, D	lay, Ybar)		INJURY	м		RK? /ES 2 [ON [
0	1	3 Suicide 6 0	Could not be	28a. PLACE O	F INJURY etc. (Speci	— At home,	farm, street	, factor)	, office			281. LO	CATION (Street a	nd Number	or Rural Ro	ute Number,	
TE		4 Homicide d	letermined									J.,	, or town, orace,				
10	٧		IFYING PHYS	ICIAN: To the best of	my knowl	ledge, death	occurred at	the time	, date	and place	, and due	to the ca	euse(a) and mar	ner as stat	ed.		
Ö	Л	one) 2 MEDI	CAL EXAMINE	R: On the basia of a	xamination	n and/or Inve	stigation, in	my opir	Hon, de	eath occur	red at the	ilme, det	a and place, an	d due to th	e cause(a)	and manner	as stated.
BB	[296. SIGNATURE AND TITLE	OF CERTIFIE	1	M.	Λ				29c. LICI	ENSE NUM	BER	2	29d. DAT	E SIGNED	Month, Day, 1	Ybar)
70	- 11			7						0.9	16	220	->	<u> </u>	5/16	, -9	5
5		30. NAME AND ADDRESS OF		M.D.					+~	00+	ħTT:	т.	Jach i	~±		G	
	-	31. DATE FILED (Month, Day)	(bar)	32. REGISTRA	R'S SIGN	ATURE		5	LI	eet	, NE	, V	<i>l</i> ashin	y cor	1, D		
		MAR 17	'9 3	gulia.	Davids	an Ban	delle										
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

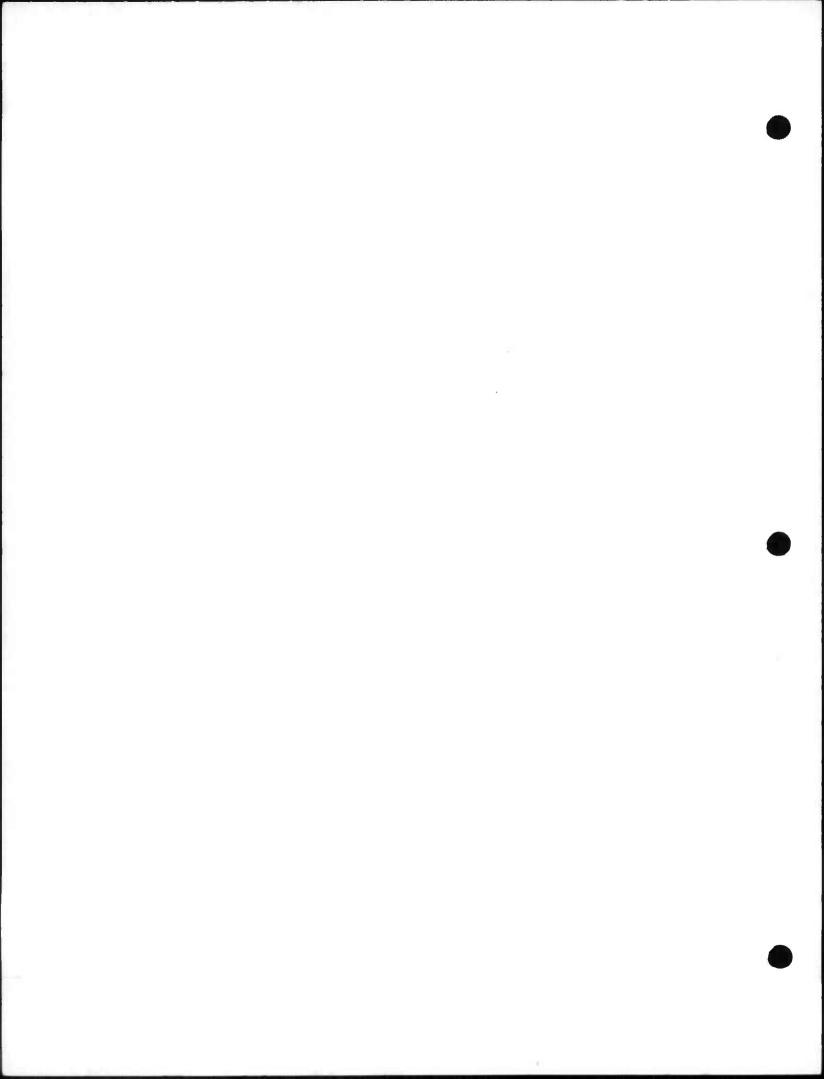


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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH													3. TIME OF DEATH				
	KATHERINE		DORR	11.1							MAR			1993	8:50 P M		
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDE	R I YEAR	-	R 24 HRS.		OF BIRTH th, Day, Year)		8. BIRTI	HPLACE (State or Foreign		
	576-11-799		1 M 2 F	16		YRS.		Larra	HOURS	MINT.	OCT.		976		INIA		
~	9a. FACILITY NAME (If not in	stitution, give s	street end number)				9b. CIT	Y, TOWN	OR LOCAT	ION OF D	DEATH 9c. COUNTY OF DEATH						
2	3016 BEAVE		LANE	LANE					R SPI	RING			N	10NTC	OMERY		
EC	10e. STATE	10b. COUNT	Y	-		10c. CITY	Y, TOWN	OR LOC	ATION						10d. INSIDE CITY		
3016 BEAVERWOOD LANE SILVER SPRING M RESIDENCE OF DECEDENT 100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION MARYLAND MONTGOMERY SILVER SPRING											LIMITS?						
	10e. STREET AND NUMBER		SILV		OF KIL				TIZEN OF	WHAT COUNTRY?							
100. STREET AND NUMBER 3016 BEAVERWOOD LANE 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 1/2 NO									20906 USA								
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED								ECENDENT	OF HISPAI	NIC ORIGI	N? (Specify Ye		14. RAC	E American Indian,		
												Rican, etc.)		Spec	k, White, etc.		
3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES** 1 YES 2 X NO Specify:												İTE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) (She kind of work done during most of working life. December (1992) (She kind of work done during most of working life. De NOT use retired.)																	
Elementary/Secondary (0-12) College (1-4 or 5 +) CTITITENTE										1							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STUDENT 16. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 16b. KIND OF BUSINESS/INDUSTRY 17c. FATHER'S NAME (First, Middle, Leat) 18c. NOTHER'S NAME (First, Middle, Meiden Surname)																	
	KEVIN I		D										,				
BE	190. INFORMANT'S NAME (7)		11		19b.	MAILING	ADDRES	ROBERTA E. GNEUHS PRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
2	KEVIN L. DOF	RR	(FATH	ER)					OOD L						YLAND 20906		
	20a, METHOD OF DISPOSITI	ON		20b.	PLACEAR	DDATEO	F DISPOS	SITION (AWL	OAT		CATION -				
}	4 Donation 5 Other	(Specify)	oval from State	- GA	ATE (etory or other	har place) F.AVF.	N C	EMETE	RY	3/1	8 5113	FR S	PRIM	G.MARYLAND		
ŀ	21. SIGNATURE OF FUNERAL	L SERVICE LIC	CENSEE				22.	NAME .	AND ADDRE	SS OF FA	CILITY						
į	1/m	HII	JHCa	mr	1.1	10							ERAL HOME, INC. SIL.SPR.,MD.20901				
	23. PART i. Enter the di	seases, or o	pmplications the	t caused	the dear	th. Do n	ot anter	r tha m	ode of dy	Ing. auc	h as car	dlec or reso	STL.	SPR.	MD 20901		
	ahock, or he IMMEDIATE CAUSE (Fin	part renure.	List only one ceu	ise on ec	ch ilne.	0					1				interval Between Onset and Death		
	disease or condition resulting in death)	→	. Don	ni	10	Vor	211		Fa	16	///	10			7 8-		
İ	resulting in death)		OUE TO	TOR AS A	CONSEDU	ENCE OF			7 60	100	UU				Lacy		
<u>z</u>	Sequentially list conditi	000	Cyp	Ei	e	V	K	6	200	20	1						
	if any, leading to immediate. Enter UNDERLY	diata	OUE TO	(OR AS A	CONSEQU	JENCE OF):										
글	CAUSE (Disease or injusting initiated events		c. DUE TO	(OR AS A	CONSECU	IENCE OF	3.										
HILLICATION	resulting in death) LAST	r		(0111011	00110200	LIVOL OF	,-										
5			d														
╡║	PART il. Other algniffcar	nt condition	a contributing to	deeth bu	it not re	sulting in	n the ur	nderiyl	ng cause	given in	Pert i.	24a. WAS AN		24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
EDICAL												1 TYES	NO		COMPLETION OF CAUSE OF DEATH?		
ž															1 _ YES 2 _ NO		
HYSICIAN:																	
3	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		_		OTHE		PLACE OF C	EATH (Ch	eck only or	ne)					
<u> </u>	1 YES 2 NO		1 Inpatient 2 I		_	DOA 28b. TIME			me 5 R	sidence							
7	1 Natural 5 🗆 I	Pending	(Month, D	ay, Year)		INJU	JRY M	W	JURY AT ORK? YES 2	¬ NO	28d. OE	SCRIBE HOW	NJURY OC	CUREO			
	a Contactor	nvestigation	28e. PLACE O	F INJURY	— At hom-	e, farm, st				_ NO	28t. LOC	ATION (Street	and Numbe	r or Rural 6	Pouto Number		
	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, str building, etc. (Specify)								Reet, factory, office 28t. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)								
291. LOCATION (Street and Number or Rural Route Number, City or Town, Steet) 292. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner as stated.																	
(Check only one) 2 MEDICAL EXAMINER: On the basis of my knowledge, death occurred at the time, date end place, end due to the cause(a) and menner as stated. MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner as stated.) end manner se stated.						
N N	Police!	100	Zi	n 6	1	nn)		01	7	110	92	≥ 50. DA	2//	6193		
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEA	TH (ITEM	27) (Type,	Print)		IVe C	-6 -1	10	7.5		11	400		
	ROBERT FINK	. M.D.					0.1	T.1 T/	T.7 A	CHIM	ርጥርነ፣	D.C.	200	10 24	270		
		93	32. MEGISTRA	BYS SIGNA	TURE -			V W	WA	OUTM	GION	, D.C.	200	10-2	7/0		
	MAR 18	93	guna L	MUY dispos	A-Man	JOSE EL											



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0	executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	n and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
BALTIMORE, MARYLAND 21215-0020	Page 1	e bud
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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TO THE HOSPITAL OF ATTENDING PHYSICIAN: The Law mouthings that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FUNCTIAL DIRECTION TO THE BUSINESS THE BEST TO BE SHOULD BY THE STRENGTHE PRINCE IN BY THE FUNCTION DAY SHOULD BE GETACH	стета	
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		FOR STATE REGISTRAR	STATE OF N					EALTH AND DEATH	MENTAL	HYGIEN REG. NO				
	1	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE O		AY	YEAR	3. TIME OF DEATH	
		Harry S. Deane							March	13,19	993	TEAN	10:10A.M	
		4. SOCIAL SECURITY NUMBER	5. SEX		s. lest birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH Day, Year)		Coun	HPLACE (State or Foreign	
		578-05-2298	1xxM 2 □ F	75	YRS.		1267	21/23 N	Oct.	7, 1	917	Wasl	hington, D.C.	
DIRECTOR		99. FACILITY NAME (If not institution, give s 8310 20th Ave.	treet and number)	end number) 9b. CITY, TOWN OR LOCATION OF DEATH Adelphi							24. 30%	ince	Georges	
1 5		RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y		10c, CI	ry, TOWN (OR LOCAT	ION			-		10d, INSIDE CITY	
1 20		Maryland Prince	Georges		0.00	elphi		1711					LIMITS?	
		10a. STREET AND NUMBER	: Georges		Aue	sthut		ZIP CODE			10a. CIT	TIZEN OF	WHAT COUNTRY?	
FUNERAL		8310 20th Ave.					1	20783						
2		11. MARITAL STATUS	12. WAS DECEDEN			13.	WAS DEC	ENDENT OF HISPAI	NIC ORIGIN?	(Specify Yes		J.S.,	E - American Indian.	
β		1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W WW 11	AH OR DATES	□NO:		if yes, sp	2 X NO Specif	an, Puerto Ric	en, etc.)		Spec	ck, White, etc.	
COMPLETED											1			
٩		12		I	river/	Sal	esma	ın	An	erica	an Sa	ales	Co.	
8		17. FATHER'S NAME (First, Middle, Last)	-					18. MOTHER'S NA	ME (First, Mic	kile, Maiden	Sumame)			
BE		Harry Deane Nellie Butler												
2		19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
-		Helen C. Deane			8310 2	20th	Ave.	Ade1ph:	i, MD	20783	3			
		20a. METHOD OF DISPOSITION 1) XBurial 2 Cremation 3 Rem	oval from State	cemeters	CEAND DATE	other place)				20c. LO			W 1 0 000	
	ı	4 Donation 5 Other (Specify)	4	Ceda	r Hill	Cem	eter	y 3/		Suit	tland	l, MI	D	
	1	Form /	TION	Ro. 1	1			11 s Fur		Home			uitland Rd. tland, MD2074	
\vdash	7	23. PART I. Enter the diseases, or o	omplications the	t caused the	death. Do	not enter	the mo	de of dylna, suc	h as cardia	c or resp	iratory as	rest	Approximata	
ļ	ı	snock, or heart failure.	List only one cau	ise on each	line.			-,g,			watery as	,	intarval Between Onset and Death	
		IMMEDIATE CAUSE (Final disease or condition	Sava	44 4-17 5	don	0	1			.1	1		Onset and Death	
1	H	resulting in death)	a. SGVa.	(OR AS A COI	NSEQUENCE O	F):	La	VC 10VO	ma	1	101	9	6 minter	
z						w	, He	me	tasi	50		0	i	
CERTIFICATION		Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CO	NSEQUENCE O	F):								
3		cause. Enter UNDERLYING CAUSE (Disease or Injury	с											
E		that initiated events	DUE TO	(OR AS A CO	NSEQUENCE O	F):								
H		resulting in death) LAST	d											
1	- 11	PART II. Other significent condition	s contributing to	death but n	ot resulting	In,the un	derlylno	cause given in	Part I. 2	4a. WAS AN	AUTOPSY	24	b. WERE AUTOPSY FINDINGS	
MEDICAL		well diffe	venti	uto 1	1 Ac	den	4) 6		una	DEDEG	RMED?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
<u>□</u>			1.1	00	0	1	1		- 9	☐ YES	NO		OF DEATH?	
=	l		0/) T	the -	100	5 /		0	- 1				1 TES 2 7 NO	
PHYSICIAN:		25. WAS CASE REFERRED TO MEDICAL					26. PL	ACE OF DEATH (Ch	eck only one)					
S		EXAMINER?	HOSPITAL:	ER/Outpatier	w 3 □ DOA	OTHER		11		0				
1		27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIN	E OF	28c, INJ	JRY AT		RIBE HOW I	NJURY OC	CURED		
12		Netural 5 Pending	(Month, D	ay, Year)	IN.	JURY M		RK? ES 2 NO						
8	ì	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE O	F INJURY - A	t home, farm,	street, fact	ory, office					er or Rural	Route Number,	
[3	7	4 Homicide determined	punaing,	atc. (Specify)					City or	Town, State)				
P.L.		29a. CERTIFIER CERTIFYING PHYSI	CIAN: To the best of	my knowledne	, death occurr	ed at the s	ime. date	end place, and due	to the cause	(a) and m-	nner ee ee	ted		
COMPL													(a) and manner as stated.	
	- 10	19 SIGNATURE AND VITLE OF CERTIFIE						29c. LICENSE NUI						
BE		David	1 11 ms	00	0	1 - 1			8 3 -	5	Z9d. DA	2	0 (Morth, Day, Year)	
2		30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAU	SE OF DEATH	(ITEM 27) (Type	, Print)		1000	, , ,			1/		
	100													

David K. Cromwell M.D. 831 University Blvd.#37 Silver Spring.

31. DATE FILED (Month, Day, Your)

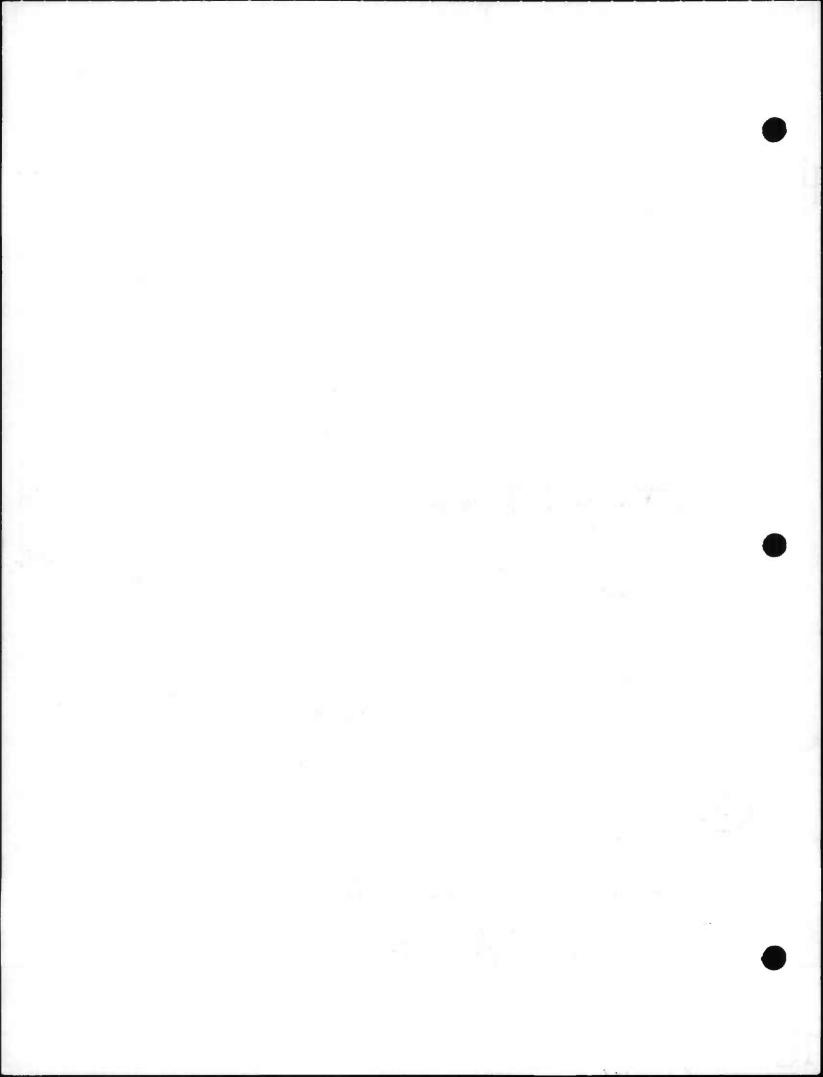
AR 0 9 1993

32. REGISTRAN'S SIGNATURE

And David K. Cromwell M.D. 831 University Blvd.#37 Silver Spring.

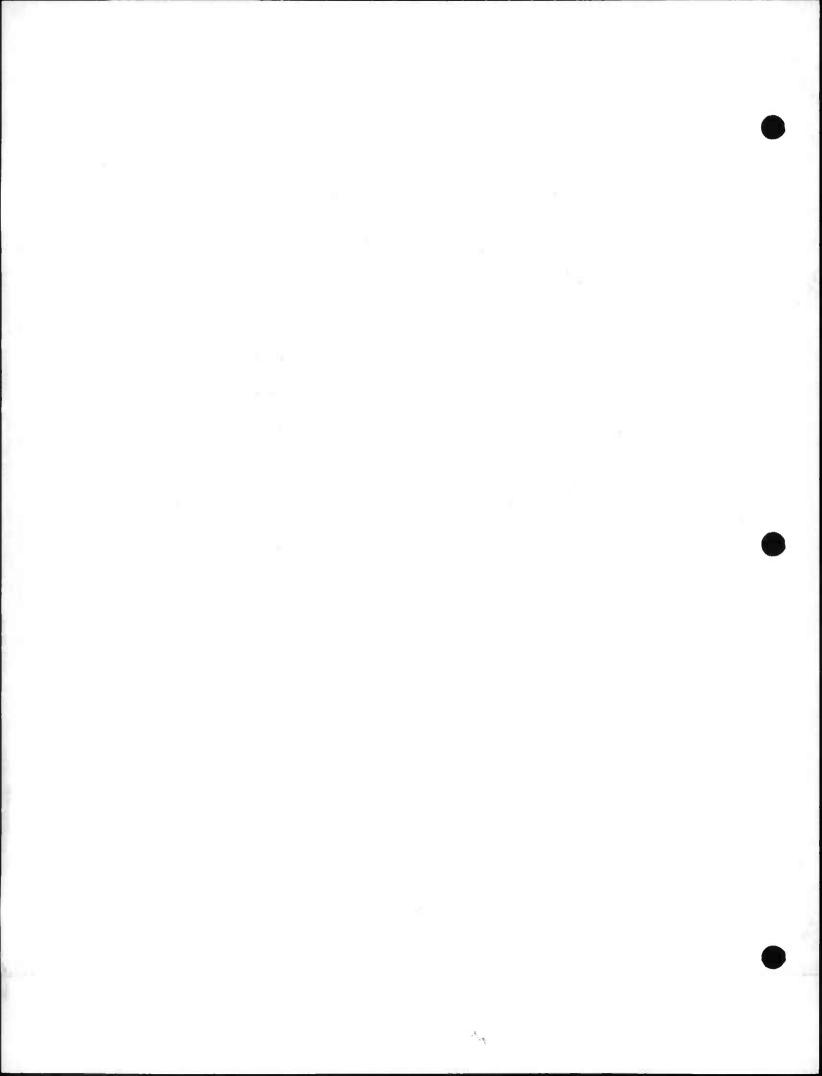
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ithin 24 hours after death. Page 6 may be retained by the h	signed by the attending physician and completely filled in by the funeral director, page 5 should be det	
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may	f. pa	
Page 6	directo	
death.	funeral	
after	y the	noval
SIN	5	Ir rel
4 10	Filled	0,00
within 2	DR: After this certificate has been signed by the attending physician and completely filled in by	Agiene prior to burial, cremation,
ICIAN: The law requires that the death certificate be executed within	nd corr	burial,
8	37 3	2
ate b	NySicia	prior
certific	ling pl	ygiene
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	FOR	CTATE OF 1	AADVI AND	/ DEDAR	TRACKT OF	UEALTH AND	450741 11	MOIEN	-	3 (18732	
	1 - STATE REGISTRAR	SINIE UF I			ICATE OF	HEALTH AND I		YGIENI EG. NO.	t			
	1. DECEDENT'S NAME (First, Middle, Last) Daniels . Lotho	Lotha	Wri	ght	Da	niel	2. DATE OF I	DEATH DA	NY C	YEAR 93	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 578-32-0628	5. SEX 1 M 2 X F	6. AGE (In yrs. In	YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B (Month, Day Janua	(Manr)		Country)	innati,Ohio	
-	Sa. FACILITY NAME (If not institution, give s					9b. CITY, TOWN OR LOCATION OF DE					TY OF DEATH	
DIRECTOR	Greenbelt Nursin	ng Home			Gre	enbelt	Prin			nce G	eorges	
REC	10s. STATE 10b. COUNTY	-		10c. CIT	Y, TOWN OR LOCA	ATION				8	10d. INSIDE CITY LIMITS?	
		nce Georg			Greenbe						1 X YES 2 NO	
FUNERAL		Greenbel ng Home	t Road		19	20770					tates	
NS S	11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A	RMED	13. WAS DE	CENDENT OF HISPAN	IC ORIGIN? (S	ecify Yes		14. RACE -	- American Indian	
A	1 Never Married 2 Married 3XXWidowed 4 Divorced	IF YES, GIVE V		,NO	If yes, a	pecify Cuban, Mexican S 2XXNO Specify	n, Puerto Rican	, etc.)		Black, Specify.	White, etc. Black	
ETED	15. DECEDENT'S EDUC (Specify only highest grade	completed)		ECEDENT'S Give kind of ve a. Do NOT us	USUAL OCCUPAT	ION lost of working	16b. KIN	OF BUS	HNESS/INC	DUSTRY		
12	Elementary/Secondary (0-12)	College (1-4 or 5-	F)			t & Missi	ionary	9	Self-	-Empl	oved	
COMPL	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NAI		-		2	0,00	
BE	Sherman			ght		Molli						
5	194. INFORMANT'S NAME (Type/Print) ([Edith L. Burno &	3				and Number or Rural F					d 20722	
	20e. METHOD OF DISPOSITION 1 A Buriel 2 Cremation 3 Remo		20b. PLACE	AND DATE	OF DISPOSITION /A	lame of	DATE			City or Town		
	4 Donation 5 Other (Specify)		Fort	Linc	coln Cem			Bren	ntwoo	od, Ma	aryland	
	21. SIGNATURE OF FUNERAL SERVICE LIC	SENSEE				AND ADDRESS OF FAC	Lat				1 Home	
				_		Georgia <i>F</i>					C.20011	
	23. PART I. Enter the diseases, or can shock, or heart failure.	List only one cau	t caused the d	eath. Do r e.	not enter the m	ode of dying, such	n as cardiac	or respli	ratory an	rest,	Approximate interval Between	
	iMMEDIATE CAUSE (Final disease or condition resulting in death)		Car	Ria	ic al	rect	_				Onset and Death	
		DUE TO	(OR AS A CONSE	OUENCE OF	F):						ises.	
1	z ASCUTO Years'									The same		
NOI	Sequentially list conditions,	b	(OR AS A CONSE	OUENCE OF	F):							
CATION	if any, leading to immediate cause. Enter UNDERLYING	b. DUE TO	(OR AS A CONSE	OUENCE OF	F):							
TIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	c	(OR AS A CONSE									
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	c										
	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSE	OUENCE OF	F):	ng cause given in	Part I. 24a	WAS AN PERFOR			WERE AUTOPSY FINDINGS	
	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	OUENCE OF	F):	ng cause given in			MED?	1		
MEDICAL	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	OUENCE OF	F):	ng cause given in		PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDICAL	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition A CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	OUENCE OF	in the underlyle	ng cause given in I	_ 10	PERFOR	MED?		MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
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BY PHYSICIAN: MEDICAL	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	DUE TO d. s contributing to MOSPITAL: 1 Inpatient 2 28a. DATE OF (Month, D)	death but not LULY ER/Outpatient: INJURY ay, Year)	resulting I	In the underlylr 26. F OTHER: 4 D-Mursing Hot E OF 28c. IN WY W	PLACE OF DEATH (Che The 5 Residence JURY AT ORK? YES 2 NO	1 [1 1	PERFORI	MED?	CURED	MANLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!	
BY PHYSICIAN: MEDICAL	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	DUE TO d. s contributing to MOSPITAL: 1 Inpatient 2 28a. DATE OF (Month, D)	death but not	resulting I	26. P OTHER: 4 Priuraing Hot URY M 1	PLACE OF DEATH (Che The 5 Residence JURY AT ORK? YES 2 NO	1 [ck only one) 6 Other (Sp.	PERFORI	MED?	CURED	MANLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!	
BY PHYSICIAN: MEDICAL	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only)	B contributing to B contributing to CONTRIBUTION HOSPITAL: 1 Inputent 2 28a. DATE OF (Month, D) 28b. PLACE O building.	death but not BER/Outpetlent: INJURY ay, Year) F INJURY — AI he etc. (Specify)	resulting I	26. P OTHER: 4 Nursing Hot E OF 28c. IN URY W 1 street, factory, offi	TLACE OF DEATH (Che me 5 Residence JURY AT ORK? YES 2 NO ce	1 [Other (Sp. 28d. DESCRIE 28f. LOCATIOn City or 7or to the cause(a)	PERFORI YES 2 Hotily) E HOW IN Vr., State)	MED? NO NJURY OCI Ind Number	CURED or Rural Root ted.	MANLABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY 1 YES 2 NO	
COMPLETED BY PHYSICIAN: MEDICAL	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only)	BUE TO d. B contributing to MODE HOSPITAL: 1 Inpetient 2 28a. DATE OF (Month, D 28e. PLACE O building,	death but not BER/Outpetlent: INJURY ay, Year) F INJURY — AI he etc. (Specify)	resulting I	26. P OTHER: 4 Nursing Hot E OF 28c. IN URY W 1 street, factory, offi	TLACE OF DEATH (Che me 5 Residence JURY AT ORK? YES 2 NO ce	1 [1 Dick only one) 6 Other (Sp. 28d. DESCRIE 281. LOCATION City or You to the cause(a)	PERFORI YES 2 Hotily) E HOW IN Vr., State)	MED? NO NURY OCC And Number There as stated due to the	CURED or Rural Root ted.	MANLABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY 1 YES 2 NO	
BE COMPLETED BY PHYSICIAN: MEDICAL	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO d. B contributing to CANOLO 28a. DATE OF (Month, D 28a. PLACE O building, CIAN: To the best of a	death but not BER/Outpetlent: INJURY ay, Year) F INJURY — AI he etc. (Specify)	resulting I	26. P OTHER: 4 Nursing Hot E OF 28c. IN URY W 1 street, factory, offi	PLACE OF DEATH (Che me 5 Residence JURY AT ORK? YES 2 NO ce a and place, and due death occured at the	1 [1 Dick only one) 6 Other (Sp. 28d. DESCRIE 281. LOCATION City or You to the cause(a)	PERFORI YES 2 Hotily) E HOW IN Vr., State)	MED? NO NURY OCC And Number There as stated due to the	CURED or Rural Root ted.	MANLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO ure Number, and manner as stated,	
COMPLETED BY PHYSICIAN: MEDICAL	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO d. B contributing to MODE HOSPITAL: 1 Inpatient 2 28a. DATE OF (Month, D) 28b. PLACE O building, CIAN: To the best of a	death but not BER/Outpetlent: INJURY ay, Year) F INJURY — AI he etc. (Specify)	resulting I	26. POTHER: 4 Privilege Hotel	PLACE OF DEATH (Che me 5 Residence JURY AT ORK? YES 2 NO ce a and place, and due death occured at the	1 [Other (Sp. 284, LOCATIOn City or You to the cause(a) Hime, date and IBER	PERFORI YES 2 Hotily) E HOW IN Vr., State)	MED? NO NURY OCC And Number There as stated due to the	CURED or Rural Root ted.	MANLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO ure Number, and manner as stated,	



HATTENDING PRESIDENT. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

RECTOR After this certificate has been agoed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Date, or freeth and Mental Hydrine prior to burial, cremation, or removal.

Here 28 is marked, or liest 20 shows any injury, or other traumatic event, the medical examiner must be notified at once.

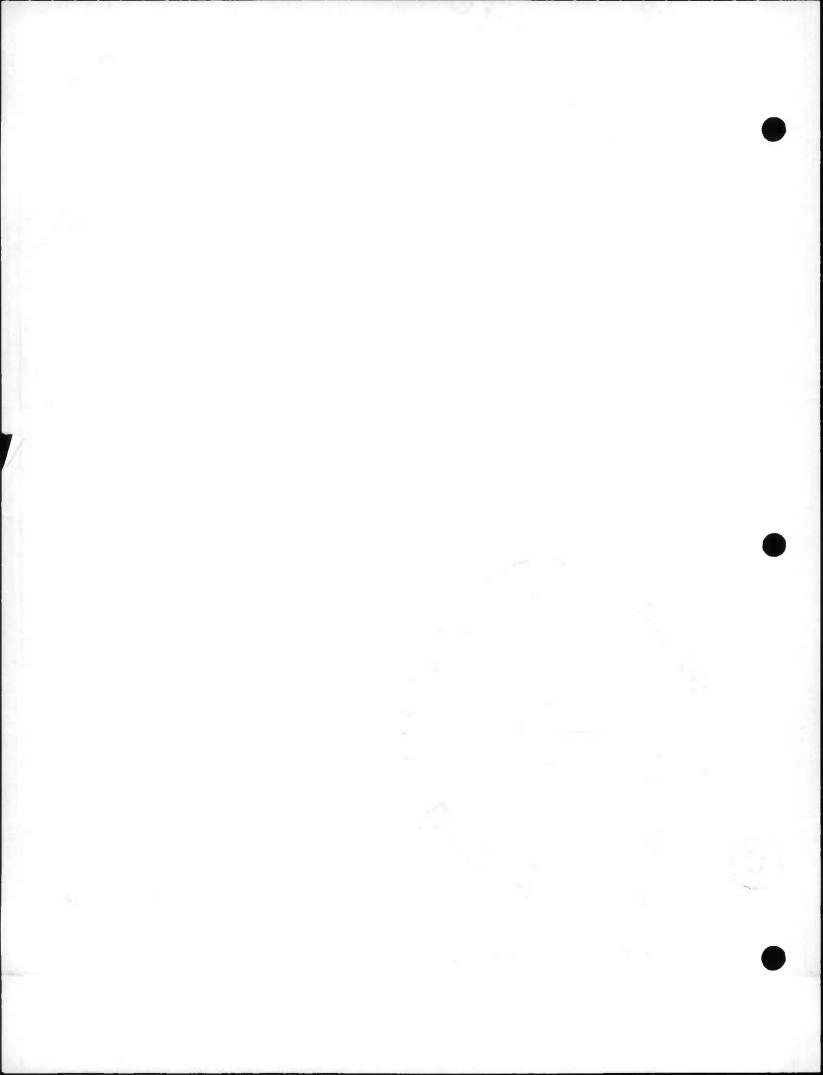
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1	-	FOR STATE REGISTRAR
Г	1 D	ECEDENT'S NA

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 2. (A) 2. DATE OF DEATH MONTH DAY YEAR 2. (A) 2. (A) 2. (A) 3. TIME OF DEATH MONTH DAY YEAR 2. (A) 3. TIME OF DEATH MONTH DAY YEAR 2. (A) 3. TIME OF DEATH MONTH DAY YEAR 2. (A) 3. TIME OF DEATH MONTH DAY YEAR 2. (A) 3. TIME OF DEATH MONTH DAY YEAR 2. (A) 3. TIME OF DEATH MONTH DAY YEAR 2. (A) 3. TIME OF DEATH MONTH DAY YEAR 2. (A) 3. TIME OF DEATH MONTH DAY YEAR 2. (A) 3. TIME OF DEATH MONTH DAY YEAR 2. (A) 3. TIME OF DEATH MONTH DAY YEAR 2. (A) 4.													
	Laverne B Dudman						,		3-8	-93		7319 M		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UNDER	DAYS	HOURS	MIN.	7. DATE OF BII (Month, Day,	Year)	Co	RTHPLACE (State or Foreign untry)		
	557-20-2794 9e. FACILITY NAME (If not institution, give s		L	71 YRS.	March 12, 1921 Missour									
8			Center								Prince George's			
5	Prince George's F		Genter											
DIRECTOR					Y, TOWN		TION			10d. INSIDE CITY LIMITS?				
	Maryland Prince	George'	S	R1	verdale 101. ZIP CODE					100.	CITIZEN O	1 ☐ YES 2 ☑ NO		
FUNERAL	6013 Mustang Driv	r e					20737	_		United State				
2	11. MARITAL STATUS	ARMED		WAS DEC	ENDENT (OF HISPA		IIC ORIGIN? (Specify Yes or No. 14, RACE - Ar						
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT FORCES? IF YES, GIVE N 1943-1		_ NO		1 Tyes, sp	2 NO	Specii	an, Puerto Rican, ly:	etc.)		beck, White, etc. White		
									16b. KINO	166. KINO OF BUSINESS/INDUSTRY				
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5		ille. Do NOT u	se retired.)									
(Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Security Supervisor 17. FATHER'S NAME (First, Middle, Last) Norman Tr. 1 Dudman														
	Norman Irl Dudman		Jocie Mae Clubb						(e)					
) BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILIN	ADDRES	S (Street a	nd Numbe	r or Rural	Route Number, City	y or Town, State	Zip Code)					
٤	Dorothy L. Dudman		(5013 N	lusta	ing I	r.,	Riv	erdale,	Maryla	and	20737		
	20a. METHOD OF DISPOSITION 1XXBurial 2 Cremation 3 Rem	oval from State	E AND DATE	of Disposition (Name of other place) Din Cemetery 3/11/93 Brentwood, Maryland										
	4 Donation 5 Other (Specify)	CENSER	Fort	Linco	oln (emet	ery	3/	FACILITY					
	11.000	ines	M008	377	F	ort	Line	coln	Funera:	l Home	Inc	2., 3401		
	23. PART I. Enter the diseases, or o		nt caused the	death. Do	not enter	the mo	de of dy	ing i	d., Bre	r respiratory	arrest.	20722		
	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):													
ATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING													
CERTIFICATION	CAUSE (Disease or Injury that Initiated events rasulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):												
	PART II. Other significant condition	a contribution to	doub but as	A(at										
EDICAL	TANT II. Other agrinoant condition	s contributing to	death but no	t resulting	in the u	nderiyin	g cause	given in		WAS AN AUTOP PERFORMED?		24b. WERE AUTOPSY FINDINGS AMARABLE PRIOR TO COMPLETION OF CAUSE		
ED									— ¹º	YES 2 NAME		OF DEATH7		
2									-			1 NES 2 NO		
SIA	25. WAS CASE REFERRED TO MEDICAL EXAMINED?		/				ACE OF D	DEATH (C)	neck only one)	-				
PHYSICIAN:	1 PES 2 □ NO	HOSPITAL:	ER/Outpatient	3 DOA	OTHE 4 Nu		• 5 🗆 R	esidence	8 Other (Spec	elfy)				
	27. MANNER OF DEATN 1 Natural 5 Pending	28a. DATE OF (Month, I	NJURY Pay, Year)	28b. TIR	URY M	WC	URY AT PRK? YES 2	1 80	28d. DESCRIBE	NOW INJURY	OCCURED			
) BY	2 Accident Investigation 3 Suicide 8 Could not be	home, farm,	street, fac				281. LOCATION	(Street and Nur	nber or Rur	al Route Number,				
=	4 Homicide datermined						City or Town	n, State)						
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSI											e(a) and manner as stated.		
	296. SIGNATURE AND TITLE OF PERTIFIE							ENSE NU				IED (Month, Day, Year)		
O BE	Mugusto / It	ranging	MI				Hai	12	30	•	3-	9 -93		
15	30. WIME AND ADDRESS OF PERSON WH	O COMPLETED ON	SE OF DEATH (TEM 27) (Type	Print)	Pa	ber	m ()	400	4.1	nd	207118		
17	MAIL A MAIL AND A MAIL		-/-/-	1110	011	meeting.	1 66	111	- W.SC	The h	-	0 0 1 7 0		



2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

- Savidson-Randelle

Marc Shephard, MD,

31. DATE FILED (Month, Day, Year)

MAR 0 9 1993

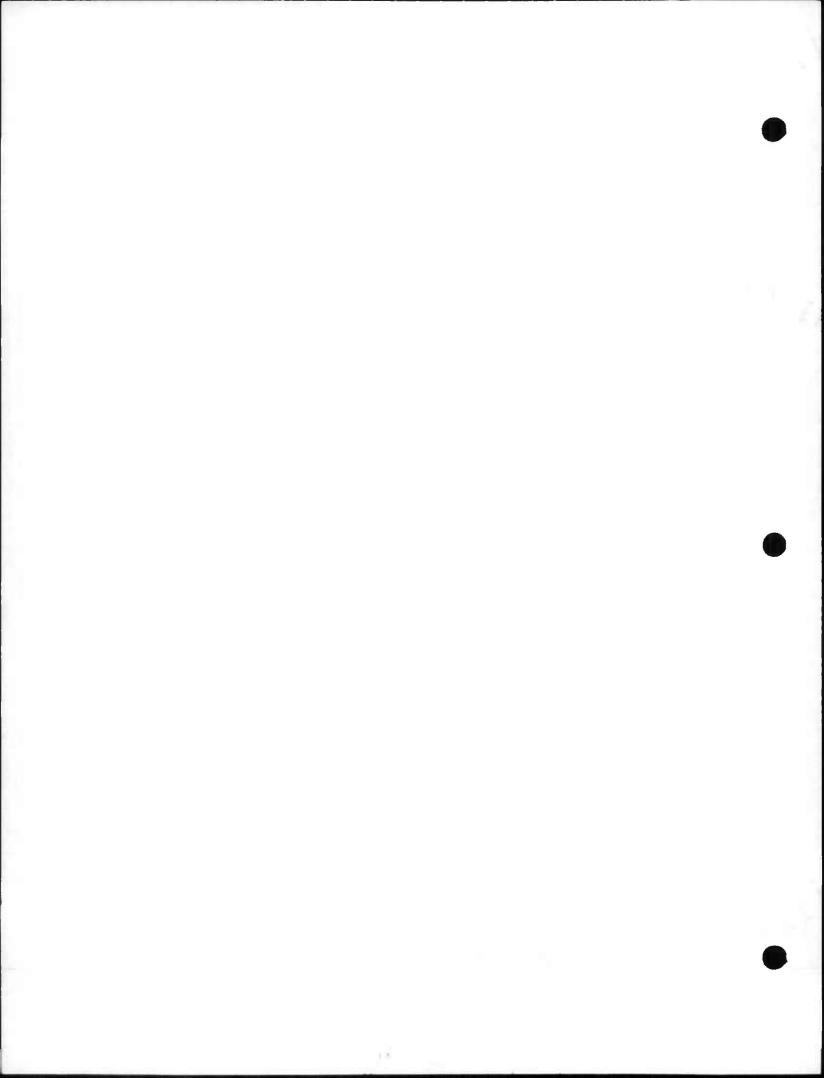
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Pages 1, 2, 3 should

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF CEATH JAMES LEO DORR 03707/1993 6:25 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 XM 2 - F YRS. 216-16-0187 73 02/19/1920 Washington, DC Sa. FACILITY NAME (If not inatitution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR 8516 Potomac Avenue College Park Prince George's RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's College Park 1X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8516 Potomac Avenue U.S.A. 20740 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Mexican, Puerto Rican, etc.)
 \(\subseteq \text{YE} \) NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married B 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 11 Machinist Private Industry notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) August P. Dorr Bertha E. Flaharety BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ruby R. Dorr 8516 Potomac Avenue, College Park, MD 20740 å 20s. METHOD OF DISPOSITION
1 Surial 2 Cremation 3 Removal from Stat
4 Donation 5 Other (Specify) DATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must Resurrection Cemetery 3/10/93 Clinton, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE/LICENSEE Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD medicei 23. PART. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liet only one cause on each line. Approximate IMMEDIATE CAUSE (Final Onset and Death 2 disease or condition resulting in death) ProstyTe recenone, metostalla event, or other traumatic PHYSICIAN: MEDICAL CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 23 shows any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? STRUCTIVE 1 YES 2 NO OF DEATH? 1 TYES 2 NO 25. WAS CASE REFERRED TO MEDICAL item : 26. PLACE OF OEATH (Check only one) **EXAMINER?** HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO e 5 🗆 Residence 6 🗆 Other (Specify) 0 27. MANNER OF DEATH 26a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 28 is marked, 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined COMPLETED 4 Homicide TO THE FLAVEHAL CHEST TO THE FLAVEHAL TO HE SHE WITHIN 72 hours IMPORTANT: If Item 2 29s. CERTIFIER
(Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, data and place, end due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Lepuis

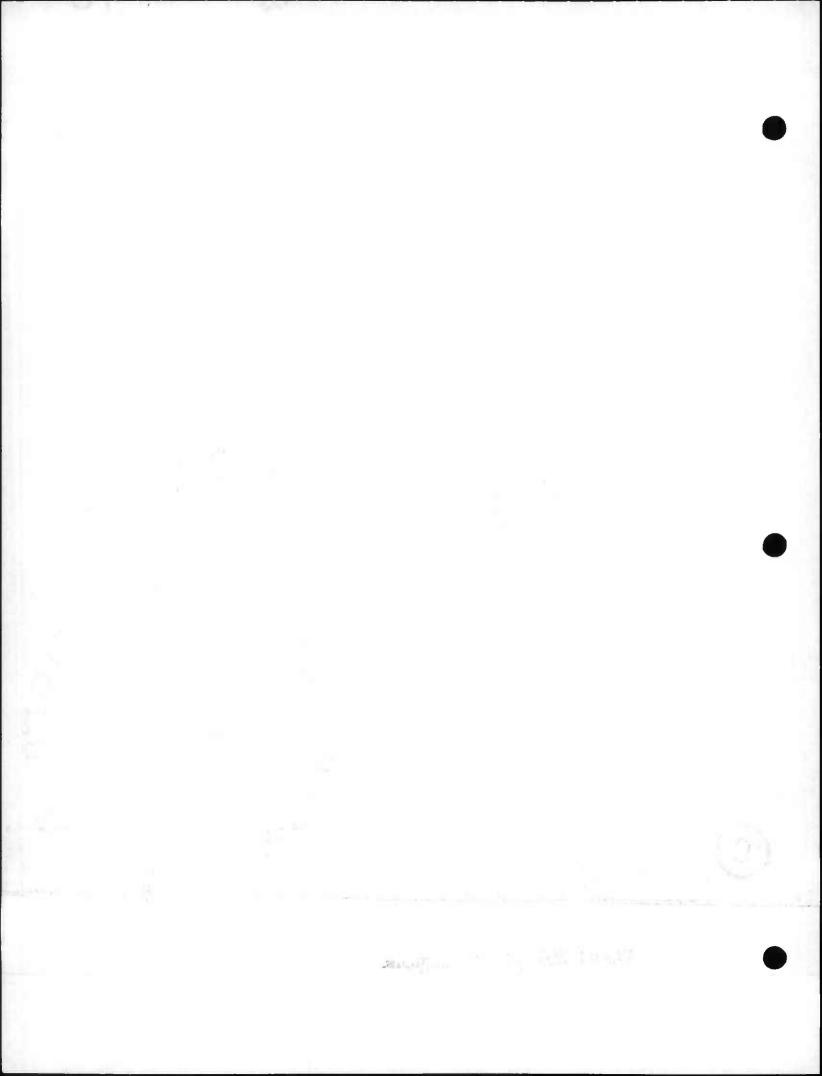
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4700 Berwyn House Road , Suite #105, College Park, MD



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OF VITAL RECORDS, P.O.	
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	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest)		MARYLAND / DE CER			DEATH		REG. N			·
		SHIRLEY	THOMAS D			4	FEE		8 199	梦 7	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 219-22-9209	5. SEX	8. AGE (In yrs. lest bire	*********	DAYS	HOURS MIN	(Mont	of Birth h, Day, Year) 29-19		Country)	CE (State or Foreign Virginia
HC.	9a. FACILITY NAME (If not institution, give Frederick Memor		tal		v, town deri	OR LOCATION OF	F DEATH		9c. COUNTY Frede		1
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	ENT CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CONTROL CO							Trede		I. INSIDE CITY
	Maryland Fred	erick		Walker	_	1e			T son CITIZE		LIMITS? YES 2 NO COUNTRY?
FUNERAL	8 Main									.S.A.	
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ VES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISP If yes, specify Cuban, Max 1 ☐ YES ZY☐ NO Spe				xican, Puerto		Yes or No — 14	Black, Wh Specify:	American Indian, white, etc.
COMPLETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	DUCATION (Give kind of work done during most of working life. Do NOT use retired.) 4 years School Teacher						ТЯУ			
BE COM	17. FATHER'S NAME (First, Middle, Last) Edward Thomas	. ,, ==================================				18. MOTHER'S Susan			len Sumame)		
5	19a. INFORMANT'S NAME (Type/Print) Edward E. Donach	V				and Number or Au ${\sf sville}$,			6wn, State, Zip Co 21793	ocie)	
1000	20a. METHOD OF DISPOSITION 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Rea		20b. PLACE AND I cemetery, cremato	DATE OF DISPO	SITION (N	ame of	DAT	E 20c.	LOCATION — CIT		
10000	4 Donation S Other (Specify) 21, SIGNATURE OF FUNERAL SERVICE L	O Do	1Smithsh	222 R	OBER	T E. DA	ILEY	& SON		L HO	MES, P.A.
CERTIFICATION	23. PART Enter the diseases, or allowed the second tender to the second tender to the second tender to the second tender to the second tender to the second tender to the second tender to the second tender to the second tender to the second tender to the second tender to the second tender to the second tender to the second tender to the second tender to the second tender to the second tender to the second tender	DUE TO DUE TO ONE	(OR AS A CONSEQUENT OR AS A CONS	ICE OF):					printed y united		Approximata Interval Between Onset and Death I Week I Month
MEDICAL	PART II. Other significent conditions CO.PD. Heart Fair Mainvtv.t	ons contributing to	deeth but not resul	sulting in the underlying ceuse given in Part i				Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO		CON OF	RE AUTOPSY FINDINGS ILABLE PRIOR TO IPLETION OF CAUSE DEATH? YES 2 [D NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 340	HOSPITAL:	ER/Outpatient 3 🗆 0	OTHE	R:	LACE OF DEATH					
ВУ РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF (Month, D		b. TIME OF INJURY M	28c. IN.	JURY AT DRK? YES 2 NO			W INJURY OCCU	RED	
LETED 6	3 Suicide 6 Could not be 4 Homicide determined	26a. PLACE 0 building,	of INJURY — At home, etc. (Specify)	form, street, fa	ctory, offic	•	28f, LOC City	ATION (Stre or Town, Ste	et and Number or ate)	Rural Route	Number,
COMPL	29a. CERTIFIER (Check only one) 1 CERTIFYING PHY: 2 MEDICAL EXAMIN		my knowledge, death of my knowledge, death of							ause(a) and	f manner as stated.
TO BE	296. SIGNATURE AND TUTLE/OF CERTIFI) m	D			29c. LICENSE	NUMBER		29d, DATE 9	IGNED (Mor	nth, Day, Year)
	30. NAME AND ADDRESS OF PERSON W	E Ave.	SE OF DEATH (ITEM 27) H303 AR'S SIGNATURE		eric	elc, Y	MD	217	0)	\	
		93 d.c.	- A	1.00		,					



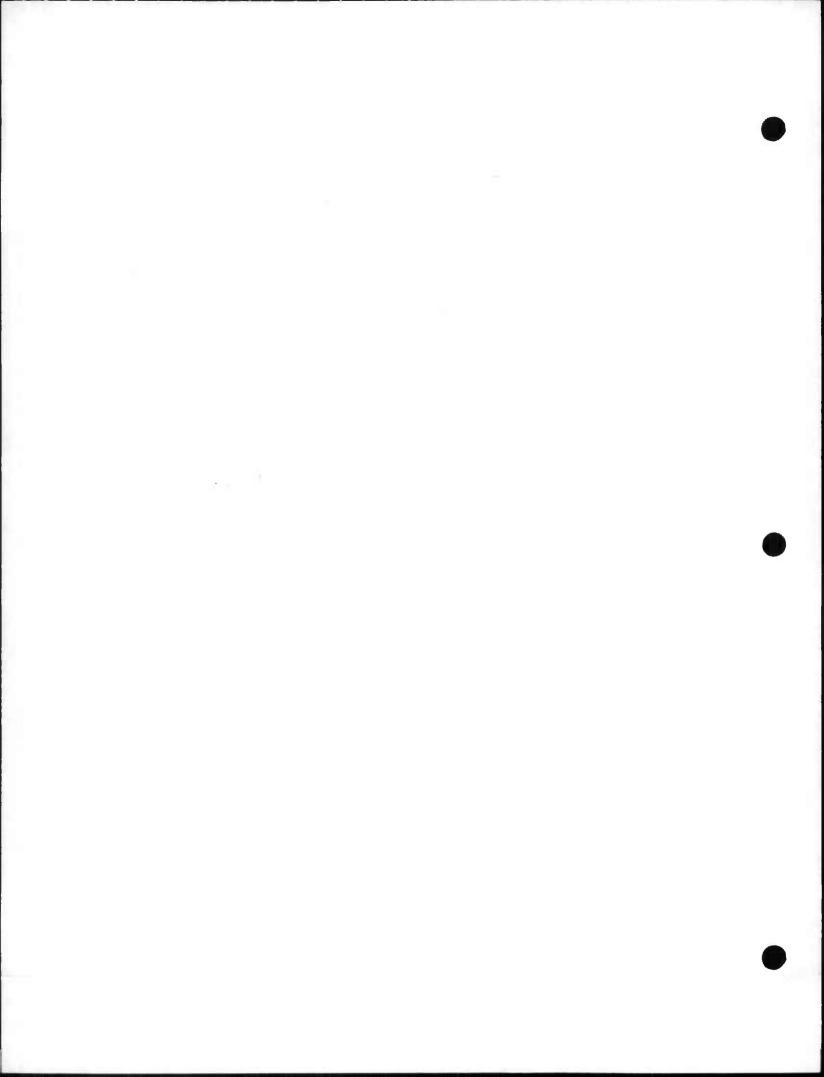
BALTIMORE, MARYLAND 21215-0020

TO THE HOPPITAL DIFFCUING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 2 after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If turn 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

- 6	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH												
	Teresa	Anne	tte DUGA	N					Feb. 26, M1993 YEAR 8:15 PM M				
	4. SOCIAL SECURITY NUMB 217-34-9187		5. SEX 1 M XXX	6. AGE (In yrs. In:	st birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Month	OF BIRTH	898	8. BIRTH	PLACE (State or Foreign
	9a. FACILITY NAME (If not in	stitution, give st	reet and number)			9b. CITY	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEAT					EATH	
CTOR	Meridian Nursing Center Fr					Frederick Frede			eder	ick			
DIRECTOR	Maryland Frederick				10c. CITY, TOWN OR LOCATION Knoxville					10d. INSIDE CITY LIMITS? 1 YES 2 NO			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	10s. STREET AND NUMBER 2242 Jefferson Pike					101. ZIP CODE 21758					10g. CITI	U.S.	WHAT COUNTRY? A.
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. AREFORCES? 1 YES 2 AND IF YES, GIVE WAR OR DATES				IMED NO	MED 13. WAS DECENDENT OF HISPANIC ORIGINAL Property (1984) 1 YES 245, 400 Specify:				N? (Specify Yes Rican, etc.)	or No-	14. RACE Black Speci	E — American Indian, k, White, etc.
COMPLETED	(Specify only highest grade completed) (C				ive kind of Do NOT u	EEDENT'S USUAL OCCUPATION ve laind of work done during most of working Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY			
BE COA	17. FATHER'S NAME (First, Mi		nnan, Sr	•				18. MOTHER'S NA			Sumame)		
70								n Pike,					58
ali eli	20. METHOD OF DISPOSITION 1 Surial 2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of Company									e, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E MO0255 22. NAME AND ADDRESS OF FACILITY Keeney and Basfo 106 East Church						sfor							
	23. PART I. Enter the di	seeses, or c	omplications that	caused the de	ath. Do i								Approximate
	anock, of heert tellure. List only one gluse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Lecture 3 4-years												
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
MEDICAL O	PART II. Other significan	nt conditions	contributing to	desth but not i	esuiting	in the un	derlying	g cause given in	In Part I. 24s. WAS AN AUTOPS' PERFORMED?			24b.	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
-				_					}				1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	ş.	HOSPITAL:					ACE OF DEATH (Ch	eck only on	10)			
YSI	1 - YES 2 NO		1 Inpatiant 2	ER/Outpatient 3	□ DOA	Num		e 5 🗆 Residence	6 🗆 Othe	r (Specify)			
ву РН		Pending investigation	28s. DATE OF (Month, Da		26b, TIM	IE OF IURY M		URY AT RK? 'ES 2 NO	28d. DES	CRIBE HOW IN	UURY OCC	CURED	
		Could not be letermined	28e. PLACE Of building, :	FINJURY — At ho mtc. (Specify)	me, farm,	street, tect	ory, office			ATION (Street a or Town, State)	nd Number	or Rural F	Route Number,
COMPLETED			CIAN: To the best of ax										e) and menner as stated,
BE	200 SCONATURE AND YIVE OF CERTIFICALLY						29c. LICENSE NUI	MBER 75	- [29d. DATI	E SIGNED	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF	PERSON WHO	CATED CAUS		M 27) (Type		H	9 217	116			- 1 0	
	31. DATE FILED MARY 0 3 1993 32. REGISTRAR'S SIGNATURE Julia Tavidson-Aandele												
			9								-		



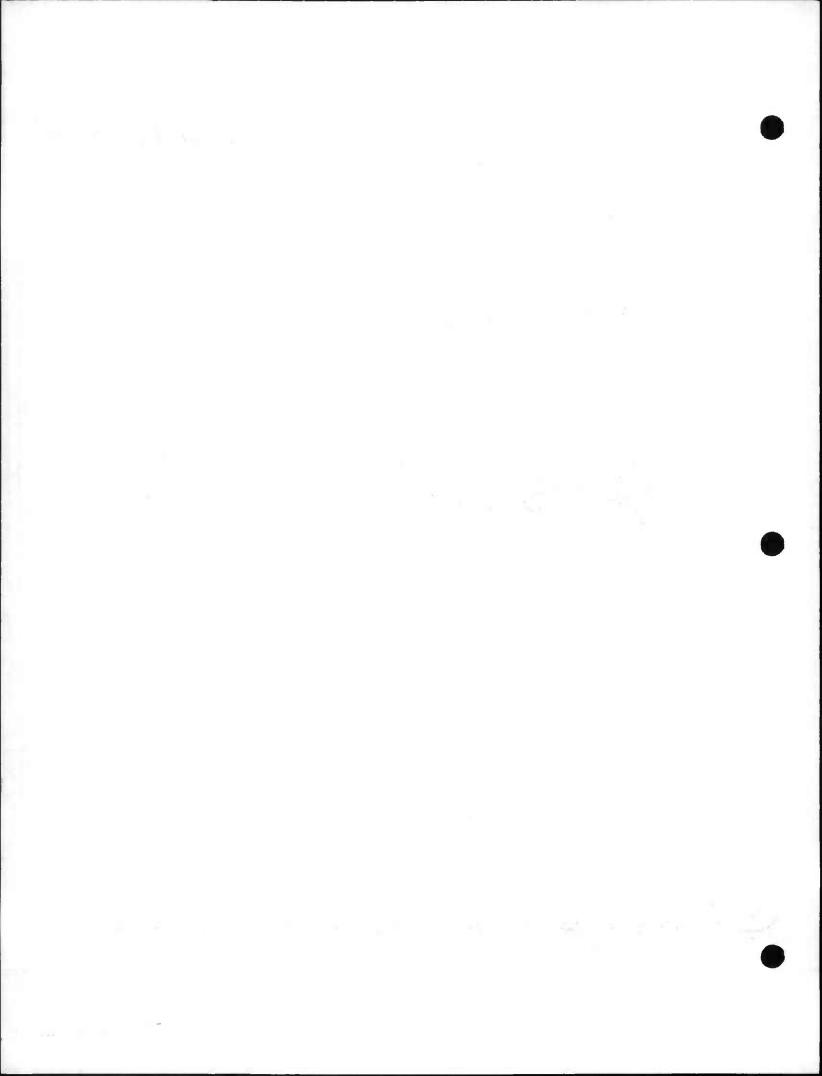
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DIVISION OF VITAL RECORDS, P.O. B	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

OTHE FUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MPDRIANT II has 28 is marked, or Ikem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAI	ND / DEPARTM			MENTA	L HYGIEN	E				
Î	1. DECEMENT'S NAME (First, Middle, Levy	1				2. DATE	OF DEATH	· O -	YEAR 3	TIME OF DEATH		
	Gordon 4. SOCIAL SECURITY NUMBER	5. SEX B. AGE //n								10-dol M		
	215-14-2699	1 3M 2 F		THE DAYS	# UNDER 24 HRS. HOURS MIN.	(Monti	h, Day, Year)	l.	Country)	ACE (State or Foreign		
	9a. FACILITY NAME (If not institution, give st	21		CITY, TOWN C	R LOCATION OF D		-6-23	9c. COUNT	ID OF DEA	ТН		
DIRECTOR	Anne Arundel Medical Center Annapolis Anne Arundel											
RE	10e. STATE 10b. COUNTY	,	10c. CITY, TO	OWN OR LOCAT	ION				10	Id. INSIDE CITY		
		Arundel_	Ar	no1d						YES 2 XNO		
FUNERAL	847 Mill Creek Ro	STREET AND NUMBER 101. ZIP CODE										
847 Mill Creek Rd. 21012 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes o							US		American Indian,			
	1 Never Married 2 Married	FORCES? 1 X YES IF YES, GIVE WAR OR DATE	2 NO	If yes, spi	city Cuban, Mexico	en, Puerto l	Rican, etc.)	Or 140	Black, V	Yhita, etc.		
BY	3 Widowed 4 Divorced	WWII	-5	1 1 163	ZXI NO Speci	ry.			Specify:	White		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade		6a. DECEDENT'S USL (Give kind of work	done during mo-	N st of working	16b	KIND OF BUS	INESS/INDU	STRY			
Ë	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re	tired.)								
M			Credit	Manage			Plast		ndust	ry		
ပ္ပ	17. FATHER'S NAME (First, Middle, Lest) Richard Le	Dukwas			18. MOTHER'S NA	AME (First, I						
H	19a. INFORMANT'S NAME (Type/Print)	ee Dutrov		DDECC (0)	Naomi		Bread	4				
2	Mildred Dutrow				ek Rd. A				(OOH)	4		
	20a. METHOD OF DISPOSITION	20b. P	LACE AND DATE OF D			DAT			ty or Town	State		
20a, METHOD OF DISPOSITION 20a, METHOD OF							•					
		5		Barra	nco Fune	ral l	Home S	95 KI	tchie	e Hwy. ck MD 21146		
-	23. PART VEnter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (DR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b.											
PHYSICIAN: MEDICAL	PART II. Other significant conditions find find		not resulting in the	ne underlying	cause given in	Part I.	24a. WAS AN PERFOR 1 YES 2	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ND			
AN	25. WAS CASE REFERRED TO MEDICAL			26 DI	ACE OF DEATH (C)	2004 004: 00						
200	EXAMINER?	HOSPITAL:		THER:								
Ϋ́	27. MANNER OF DEATH	26a. DATE DF INJURY	28b. TIME OF		5 Residence		r (Specify) CRIBE HOW II	JURY OCCU	RED			
	1 Netural 5 Pending	(Month, Day, Year)	INJURY	M 1 🗆 Y	RK? ES 2 ND							
TED BY	2 Accident Investigation 3 Sulcide 8 Could not be detarmined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, stree	t, factory, office		28f. LOC City	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLETED			cnowledge, death occurred at the time, date and place, and due nation and/or investigation, in my opinion, death occurred at the							nd manner as stated.		
	296. SIGNATURE AND TITLE OF GERTIFIER			T	29c. LICENSE NU					onth, Day, Year)		
BE C	11 Dra 1111 100561 > 3/11											
2	30. NAME AND ADDRESS OF PERSON WHO DR RIER MD.	ANNE ARUNS	DEL MED	CTR.	ANN	Apal	is, MD	. 21	40			
	31. DATE FILED (Month, Day, Year) MAR 1 5 10	32. REGISTRAR'S SIGNATION	ma Andall			100						



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE	OF MARYLAND / DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE
	CERTIFICATE	OF DEATH	REG NO

	1 - FOR STATE REGISTRAR	STATE OF MA	RYLAND /	DEPART	MENT OF H	EALTH AND		YGIENI	E		
- 1	1. DECEDENT'S NAME (First, Middle, Last)					-	2. DATE OF	DEATH			3. TIME OF DEATH
	Mary		Dunba	ar			3-	9 -	1993	YEAR	1:20 a ^M
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. les	—	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, De	BIRTH by Wear!		a. BIRTH	IPLACE (State or Foreign
	160-05-1594	1 🗆 M 2 😾 F	92	YRS.	ONINS DATS	HOURS MIN.	12-	-	900		ttland
œ	9e. FACILITY NAME (If not institution, give s	treet end number)		1	b. CITY, TOWN C	R LOCATION OF DE	EATH		9c. COUN	TY OF D	EATH
D.	Crofton Convaleso	ent Ctr.			Crofton	1			Anne	e Ar	unde1
DIRECTOR	10e. STATE 10b. COUNT	Y		10c. CITY,	TOWN OR LOCAT	ION			11		10d. INSIDE CITY
5	MD Anne	Arundel		Cro	fton		LIMITS? 1 ☐ YES 2 ☑ NO				
AL	10e. STREET AND NUMBER	335 002002		<u> </u>		. ZIP CODE			10g. CITIZ	EN OF V	WHAT COUNTRY?
FUNERAL	Crofton Conv. Ctr	. 21301 Da	vidsor	ville	Rd.				USA	٨	
E	11. MARITAL STATUS	12. WAS DECEDENT EX	VER IN U.S. AR	MED	13. WAS DEC	ENDENT OF HISPA!	VIC ORIGIN? (S	pecify Yes	or No—	14. BACE	— American Indian,
ВУ	1 Never Merried 2 Merried 3 Never Merried 4 Divorced	IF YES, GIVE WAR	OR DATES X			2 NO Specify		n, atc.)		Speci	
	15. DECEDENT'S EDU	CATION	180 DE	CEDENT'S U	UAL OCCUPATION		1		1		White
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(G)	ve kind of wor Do NOT use i	k done durina mo	st of working	166. KI	ID OF BUSI	NESS/IND	JSTRY	
딥	and the process and the process of t	College (1-4 of 5 +)	Ca	feter	ia Mana	ger	Sci	1001	of Mo	2450	ine
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			ile bel	Ta Mane	18. MOTHER'S NA				3GEC	Ine
BE	Duncan	N	1cPhers	son		Marv				ا م حاد	adder
2	19e. INFORMANT'S NAME (Type/Print)				DRESS (Street a	nd Number or Rural F	Route Number, (City or Town,	State, Zip	Code)	adder
-	James McPherson		1	837 P	leasant	Plains	Rd. Ar	napo	lis N	MD 2	1401
	20e. METHOD OF DISPOSITION 1 Burlel 2 To Cremetion 3 Rem	oval from State	20b. PLACE A	ND DATE OF	DISPOSITION /Na	me of	DATE		ATION — C		
	4 Donetion * 5 Other (Specify)			Crem			3/10	Cat	onsvi	11e	MD
	21. SIGNATURE OF TONERAL SERVICE LIC	ENSEE			22. NAME AN	D ADDRESS OF FA	CILITY				e Hwy.
	Model	dance	~ •		Barran	co Funer	al Hon				rk MD 21146
	23. PART //Enter the diseases, or cahock, or heert feliure.	complications that ca List only one cause	used the de- on each ilne.		enter the mod	de of dying, suci	n es cerdiec	or respire	atory erre	st,	Approximete Interval Between
	IMMEDIATE CAUSE (Finel disease or condition	let	1	Lan	hia	Mas	Las	lun			Onset and Death
	resulting in death)	g in death) PUE TO (OR AS A CONSEQUENCE OF):						The second of the second			
z	IMMEDIATE CAUSE (Finel disease or condition resulting in death) e. DOE TO (OR AS A CONSEQUENCE OF): DOE TO (OR AS A CONSEQUENCE OF): D. DOE TO (OR AS A CONS									new	
Ĕ	Sequentially list conditions, if any, leeding to immediate	if any, leeding to immediate									
CERTIFICATION	CAUSE (Disesse or injury	C									
Ē	thet initieted events resulting in death) LAST	DOE 10 (0H	AS A CONSEO	UENCE OF):							
		1									
AL	PART II. Other algnificant condition	a contributing to dea	th but not re	sulting in	the underlying	ceuse givan in	Part i. 24e	. WAS AN A		24b.	WERE AUTOPSY FINDINGS
							1	PERFORM YES 2			AVAILABLE PRIOR TO COMPLETION DF CAUSE
¥									_		OF DEATH? 1 YES 2 NO
PHYSICIAN: MEDIC							_				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				ACE DF DEATH (Che	ick only one)				
× ×	1 TYES 2 NO	1 Inpatient 2 ER			THER: Nursing Home	5 🗆 Residence	6 Other (Sp	ecify)			
- 1	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJL (Month, Day, Ye	JRY bar)	28b. TIME O	Y WOR	RK?	28d. DESCRIE	BE HOW IN.	JURY OCCU	RED	
`	2 Accident Investigation	28e. PLACE OF IN	HIEW As been			ES 2 NO					
	3 Suicide 8 Could not be determined	building, etc.	(Specify)	re, term, atre	et, factory, office		28f. LOCATIO	N (Street en wn, State)	d Number o	r Rumi A	oute Number,
	29e. CERTIFIER	WAN 5 W		w he	A-11	-11 7					
COMPLE	(Check only one) 2 MEDICAL EXAMINE										
	29b. SIGNATURE AND TITLE OF CERTIFIER			- Indiana	ii my opinion, ac						
R R	MC -	a Bullo L	0			29c. LICENSE NUM	187	0	29d. DATE	SIGNED	(Month, Dey, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE D	F DEATH (ITEM	27) (Rene (L.)	otl	90	10%	0	3	191	172
	MAX CFSCATA	Kaip	フェフュ	Rit	Eline.	Havy- 6	lay &	uni	a ac	0	21061
	31. DATE FILED (Month, Day Year) 5 19	SB FUNA DO	SIGNATURE	andelle							

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	3 should		
	IERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sh		
	permit.		
Sician.	ial-transit		
ding phy	the bur		
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hospital	ached fo		
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after deal	y the fun	noval.	and aver
4 hours	illed in b	n, or ren	Special Control
within 2	npietely f	crematio	As American
IN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or atten	and con	o burial.	madia a
cate be	physician	e prior t	1
ath certif	tending p	al Hygien	an ath
if the de	by the at	and Ment	. inima
drines the	n signed	I Health	000000
e law re	has beer	Dept. of	40 CC a
CIAN	ertificate	the State	or item
G PHYS	er this c	in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation	T. H them 30 is marked or them 32 shows now legions or other bearings to be made it were most no autitor at account
TENDIN	TOR: AM	after des	20 00
AL UR A	AL DIREC	2 hours	M SAC
1	ER/	in 7	F

	1 - FOR REGISTRAR	STATE OF MARYLAND C		NT OF HEALTH AND TE OF DEATH	MENTAL HYGIEN				
1	1. DECEDENT'S NAME (First Middle, Lest)	mond	LID	avis	2. DATE OF DEATH	"-93"	3. TIME OF DEATH		
	41 "	SEX 6. AGE (In yrs. In	yrs. Monte	DER 1 YEAR OF UNDER 24 HRS. IS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)		
OR	9a. FACILITY NAME (If not institution, give street ANNE ARVNE		9b. C	ANNADO		9c. COUNTY	OF DEATH JE ARUNDEI		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			N OR LOCATION		17.77	10d. INSIDE CITY LIMITS?		
	104. STREET AND NUMBER	NE ARUNDEL	Se	VERNA F	ARIC	10g. CITIZEN	1 VES 2 NO		
FUNERAL	430 Se Ues 11. MARITAL STATUS 12	. WAS DECEDENT EVER IN U.S. A		3. WAS DECENDENT OF HISPA	46 NIC ORIGIN? (Specify Ve	0 or No — 14.	S.A. RACE — American Indien,		
B⊀	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2	No	If yes, specify Cuber, Maxico 1 — YES 2 THO Specif	an, Puarto Rican, etc.)		Specify: W/H/TE		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	npleted) (i	ECEDENT'S USUAL Give kind of work do b. Do NOT use retire	ne during most of working	16b. KIND OF BU	SINESS/INDUST	RY		
OMPL	17. FATHER'S NAME (First, Middle, Last)		MGR.	18. MOTHER'S NA	RCTA	L MAA	eketin (-		
BE C	19a, INFORMANT'S NAME (Type/Print)		Avis				ELLER		
٩	RONALD L. [DAVES	430	Sexensiand Number or Rural	An Seve	RWN-	10 pk MD 21146		
	20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)		AND DATE OF DISI		3-9 A	CATION — City	or Town, Stata		
	21. SIONATURE FUNERAL SERVICE LICENS	Survivor		BARRANCE F	A Seven	RITU	tie Huy		
	23. PART I. Enter the diseases, or com ahock, or heart failure. Liet	plications that caused the d t only one cause on each lin	eath. Do not an	ter the mode of dying, suc	ch as cardiac or reap	iratory arrest,	Interval Between		
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS A CONSE	tra				Onset and Death		
N	Someonielle Hat and telegram								
CATIC	oue To (or As A consequence of): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury c.								
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSE	OUENCE OF):						
AL	PART II. Other algolificant conditions c	ontributing to death but not	resulting in the	underlying couse given in	Pert i. 24a. WAS AN PERFOI		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
PHYSICIAN: MEDIC					1 _ YES 2	: <u>NO</u>	DF DEATH? 1 YES 2 NO		
IAN:	25. WAS CASE REFERRED TO MEDICAL			28. PLACE OF OEATH (C)	eck only one)				
rsic		OSPITAL: ☐ Inpatient 2 ☐ ER/Outpatient	3 - DOA 4 - I						
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW	NJURY OCCURE	EO		
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — A1 h building, atc. (Specify)	ome, ferm, street,	factory, office	28f. LOCATION (Street City or Town, State,		tural Route Number,		
COMPLETED		N: To the best of my knowledge, d					use(e) and manner as steled		
BE CC	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NU	ered at the time, date and place, end dua to the cause(e) and manner as at ENSE NUMBER 29d. DATE SIGNED (Mgnth, Day, Year)					
10	38. NAME AND ADDRESS OF PERSON WHO CO	OMPLETEO CAUSE OF DEATH (IT)	EM 27) (Type, Print)	10 003	-61	3/	15/93		
	AR. BIERN 31. DATE FILED (Month, Day, Year)	OMPLETED CAUSE OF DEATH (ITE AVNE AR 32. REGISTRAR'S SIGNATURE 33. July Davidson	INDEL 1	MED CIR. 1	Annapolis	MD.	21401		
	MAR 1 5 199	3 Julia Davidson	- Andelle		•	,			

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	REGISTRAR		CERTIFIC	ATE OF	DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	John	Leas	Daugh	a where		MONTH DA		170 86-0	
	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR	IF UNDER 24 HRS.	03/03/9 7. DATE OF BIRTH		OF SOME W	
		1 M 2 □ F		NTHS DAYS	HOURS MIN.	(Month, Day, Year)	6. BIRT	HPLACE (State or Foreign try)	
	220-12-9808		65			04/02/27	MD		
~	9e. FACILITY NAME (If not institution, give	street and number)	96	L CITY, TOWN C	R LOCATION OF DE	ATH	9c. COUNTY OF	DEATH	
DIRECTOR	Anne Arundel Me	dical Center		Annapol	is		Anne Ar	Indol	
5				шпарот	10		AIIIE AI	.uildet	
H	10e. STATE 10b. COUNT			OWN OR LOCAT	ION			10d, INSIDE CITY	
0	MD Ann	e Arundel	Anna	polis				LIMITS?	
BY FUNERAL	10e. STREET AND NUMBER			101	ZIP CODE		10a CITIZEN OF	WHAT COUNTRY?	
3	1153 Skyway Driv	ve			2140	17	U.S.A.		
Z	11. MARITAL STATUS								
교	1 Never Merried 2 Merried	12. WAS DECEDENT EVE FORCES? 1 YE	S 2 NO	II yes, ap	ENDENT OF HISPAN ICITY Cubers Mexica	HC ORIGIN? (Specify Yes n, Puerlo Ricen, etc.)	or No- 14. RAC	E American Indian, ok, While, etc.	
≥	3 Widowed 4 Divorced	IF YES, GIVE WAR OF	DATES		2 NO Specify		Spec		
		WWT	1					White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grad	JCATION e completed)	18e. DECEDENT'S USI	JAL OCCUPATIO	N at of working	16b. KIND OF BUS	INESS/INDUSTRY		
Ш	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use re	tired.)	a working				
AP!			Baker			Grocery	Store		
ő	17. FATHER'S NAME (First, Middle, Last)		I Dake I		16 MOTHER'S NA	ME (First, Middle, Maiden S			
	Gaaraa Dawalaasi						ourrentay		
BE	George Daugherty	<u> </u>			Anna Gr	een			
5	Too. NO OTMANT S NAME (1990) THE		19b. MAILING AD	DRESS (Street e	nd Number or Rural F	noute Number, City or Town	, State, Zip Code)		
-	Mrs. Anna R. Dai	gherty	1153 Sk	way Dr	ive	Annapoli	s MD	21401	
	20a. METHOD OF OISPOSITION 1 Burlel 2 Cremation 3 Ren		Ob. PLACE AND DATE OF	ISPOSITION (Na		OATE 20c. LOC	ATION — City or To	own, State	
	4 Donalion 5 Other (Specify)		Metro Crema			24			
	21. SIGNATURE OF FORERAL SERVICE LI	CENSEE			D ADDRESS OF FA		sville.		
	·(11)00	2				495 R1	tchie Hw		
	700CA	Jarran	- 10/ I	arranc	o Funera	1 Home Sev	erna Par	k MD 21146	
CERTIFICATION	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events Due to (or as a consequence of): Oue to (or as a consequence of):								
E	resulting in death) LAST	d							
	PART II. Other significant condition	na contributing to death	but not resulting in a	ne underlulee	Cattan ohum to	Best I ac una			
DICAL			but not readiting in the	ie underlying	cause given in	Part i. 24a. WAS AN A PERFORA		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
						1 [] YES 2 [□ NO	COMPLETION OF CAUSE OF DEATH?	
뿔								1 YES 2 NO	
÷ l						_		0	
₹ I	25. WAS CASE REFERRED TO MEDICAL			26 PI	ICE OF DEATH (Che	ck only one)			
S	EXAMINER? 1 YES 2 NO	HOSPITAL:		THER:					
BY PHYSICIAN: ME	27. MANNER OF DEATH	1 inpetient 2 DER/O			5 Residenca	8 Other (Specify)			
亩	1 Netural 5 Pending	28e. DATE OF INJUR (Month, Day, Year	Y 28b. TIME OF	20c. INJU	RY AT	28d. DESCRIBE HOW IN	JURY OCCURED		
≿	2 Accident Investigation			M 1 🗆 Y	ES 2 NO				
- 4	3 Sulcide 8 Could not be	28e. PLACE OF INJU- building, etc. (Sc	RY — Al home, ferm, stress	t, fectory, office		281. LOCATION (Street en	d Number or Rural I	Route Number,	
	4 Homicide determined	building, atc. [3]	эвспу)			City or Town, State)			
ш	29e. CERTIFIER						 -		
루	(Check only	ICIAN: To the best of my kno							
COMPLETED	2 MEDICAL EXAMINE	R: On the beele of examinat	ion end/or investigation, in	my opinion, de	nth occured at the	lime, date and piece, and	due to the ceuse(e	e) and manner as stated.	
	29b. SIGNATURE AND TITLE OF CENTIFIE	R			29c. LICENSE NUM	eso T	204 DATE GIOVES		
BE	29c. LICENSE NUMBER O 2 F 6 F 6 3 3 9 3								
2	20 NAME AND AGREEM CO.				0216	0	3/3	173	
	30. NAME AND AODRESS OF PERSON WH	- 4			0				
	VICTOR PLAUN	ER MID	BAA. BL	UD	MA	RNOW Y	MA. 2	10/2	
	MAR 15 199	32 AGGISTAM'S SIG				, , ,	5.01		
	MAR 1 5 199	3 Juna varias	07 0-10-10-10-						
		124							

i may be retained by the hospital or attending physician. It is a should be defached for use as the burial-transit permit. Pages 1, 2, 3 should tor, page 5 should be defached for use as the burial-transit permit. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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Page	dire	101
A ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hose	DESTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach	Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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the de	Describe. After this certificate has been signed by the attending physician and completely filled in by the in-	Pin
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	FOR 1 - STATE REGISTRAR	STATE OF MAR	RYLAND / DEPAR CERTIF	TMENT OF I		MENTAL HYGIEN REG. NO		U8/41		
	1. DECEDENT'S NAME (First, MIDDIN, Last) JOE WOODROW	DeBUSK					AY YEA 3 93	9:00 PM		
	4. SOCIAL SECURITY NUMBER 404~18-5355 9a. FACILITY NAME (If not institution, give s	1	AGE (In yrs. lest birthdey) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		917 0	IRTHPLACE (State or Foreign ountry) Urginia		
CTOR	Anne Arundel Med RESIDENCE OF DECEDENT	· ·	1	200	apolis	ЕАТН	Anne	Anne Arundel		
L DIRECTOR	MD ANNO 10e. STREET AND NUMBER	e Arundel	10c, CIT	ч, тошн он Loca Аппар	olis		10d. INSIDE CITY LIMITS? 1 YES 2 NO			
FUNERAL	37 Oak Court				zip code	Unite	of what country?			
ΒY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 IF YES, GIVE WAR		If yes, sp		HC ORIGIN? (Specify Ye n, Puerto Rican, etc.) y:		RACE — American Indian, Black, Whita, etc. Specify: White		
APLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of the Do NOT use Superi	WOUND OCCUPATION WORK done during more retired.)	ON ist of working	186. KIND OF BU	Dr	ydock Co. Building &		
E COMPL	17. FATHER'S NAME (First, Middle, Last) Hazvey DeBusk					ME (First, Middle, Melden Alice Turn	Surname)	3		
TO B	19a. INFORMANT'S NAME (Type/Print) Leona F. DeBusk					Poute Number, City or Tow lis, Maryl				
	20a, METHOD OF DISPOSITION 1 M Murial 2 Cremation 3 Removal from State 4 Donation 8 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of camplety, crematory or other place) GLEN HAVEN CEMETERY 03-18-93 GLEN BURNIE, MD									
	21. SIGNATURE OF FUNERAL SERVICE LIC	I Dion	lus	22. NAME A	NO ADDRESS OF FA	CILITY John M	. Taylo	r Funeral Hom apolis, MD		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause of each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Approximate interval Between Onset and Daath									
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
CERTI	resulting in death) LAST	4								
MEDICAL	PART II. Other significant condition	s contributing to dee	th but not resulting	in the underlyin	g ceuse given in	Part I. 24e. WAS AN PERIFOR	RMEO?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
PHYSICIAN: N	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PI	ACE OF DEATH (Che	eck only one)				
	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	12 Inpetient 2 □ ER. 28a. DATE OF INJU (Month, Day, Ye	JRY 28b, TIM	E OF 28c. INJ	URY AT PRES 2 NO	8 Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCURE	D		
тер ву	2 Accident Investigation 3 Suicide 8 Could not be detarmined	28s. PLACE OF IN. building, etc.	JURY — At home, farm, (Specify)			281. LOCATION (Street City or Town, State)	and Number or Ru	iral Route Number,		
COMPLET		CIAN: To the best of my I						se(a) and manner as stated.		
TO BE CO	29b. SIGNATURE AND TITLE OF CERTIFIES 30. NAME AND ADDRESS OF PERSON WH	nel	et		29c. LICENSE NUN D05192		29d. DATE SIG	NED (Month, Day, Year) h 15, 1993		

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

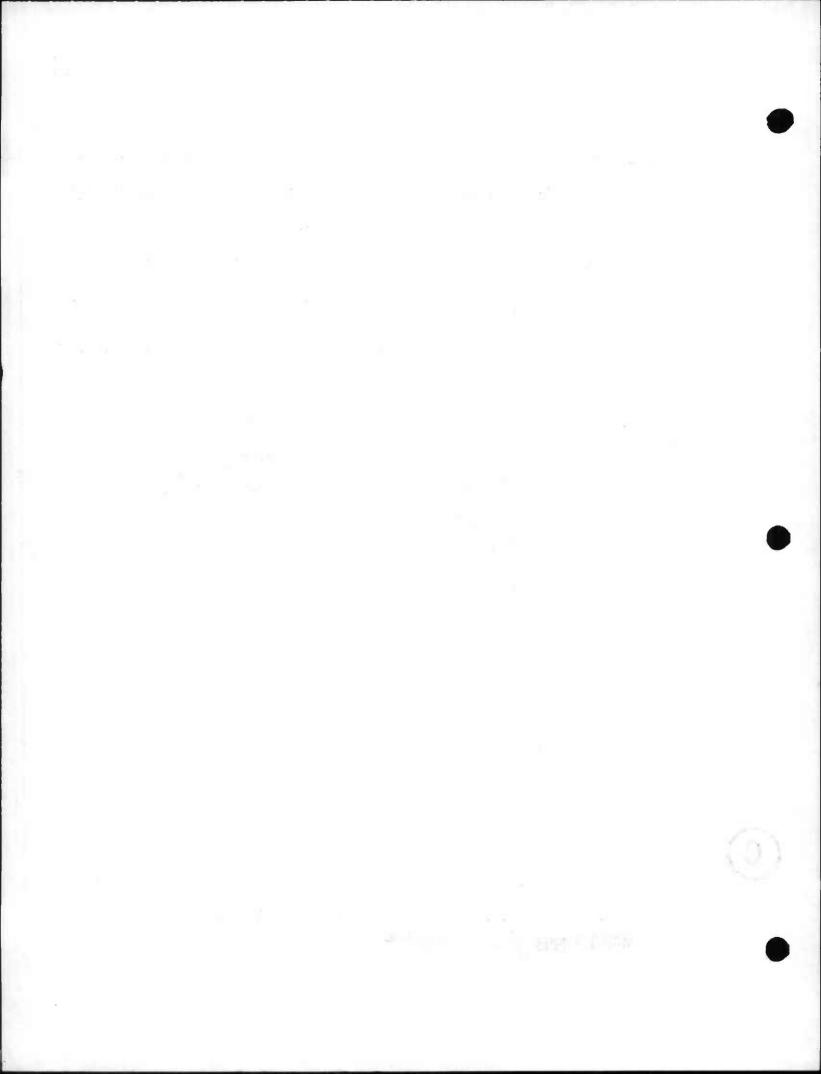
32. ARGISTRAR'S SIGNATURE Gundalle

16 Murray Avenue

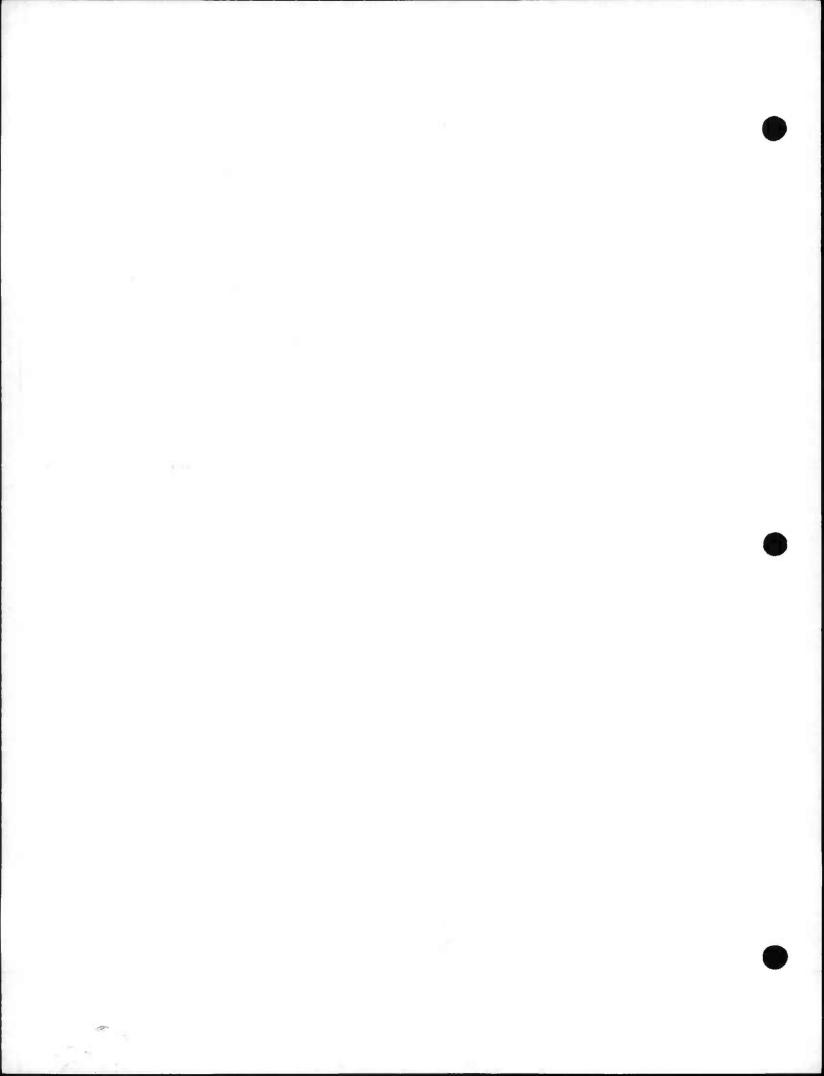
M.D.

Richard L. Hockman,
31. DATE FILED (MORTH, Day, Mar)
MAR 16 1993

Annapolis, Maryland 21401

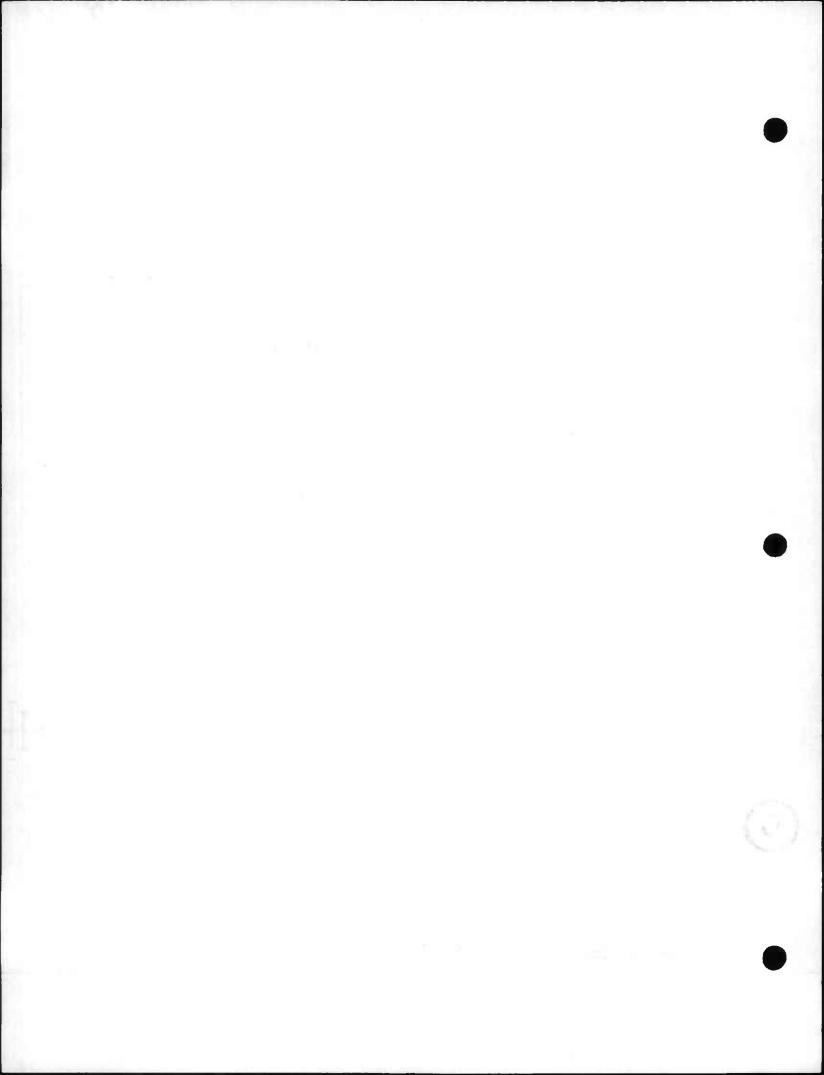


						10142			
	1 - STATE OF MARYLAND REGISTRAR) / DEPARTMENT OF CERTIFICATE O		NTAL HYGIEN REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last) CLIFFORD	E DAWSON		DATE OF DEATH		3. TIME OF DEATH 4:45 PM			
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs.		R IF UNDER 24 HRS. 7.	DATE OF BIRTH	& BIOTA	IPLACE (State or Foreign			
	478-32-3852 NXM≥□F 59	YRS. MONTHS DAY		EC. 15,1	933 10	NA NA			
DIRECTOR	9a. FACILITY NAME (If not institution, give street end number) 226 NORTH POTOMAC STREET RESIDENCE OF DECEDENT	STEEL STEEL	ERSTOWN,		9c. COUNTY OF D	HINGTON			
REC	10a. STATE 10b. COUNTY	10c. CITY, TOWN OR LO				10d. INSIDE CITY LIMITS?			
	MARYLAND WASHINGTON 10s. STREET AND NUMBER	HAGERS	TOWN			1 X YES 2 NO			
FUNERAL	226 NORTH POTOMAC STREET		21740		U.S.A				
В	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	NO If yes,	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:						
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	SINESS/INDUSTRY							
COMPLET	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) CARE PROVIDER MENTALLY RET								
OM	12 CARE PROVIDER MENTALLY RETARD 17. FATHER'S NAME (First, Middle, Malden Surname)								
BE	BILLIE JOE DAWSON		RAMONA	IRENE		PBELL			
5	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAMONA I. ROHM 1623 EAST 33RD STREET, DES MOINES, IOWA 50317								
	20e. METHOD OF DISPOSITION 1 □ Burial 2 X□ Cremention 3 □ Removel from State 4 □ Donastion 5 □ Other (Specify) □ SMITTER	CEAND DATE OF DISPOSITION SECURITY OF THE COLOR OF THE C	(Name of	DATE 20c. LO	CATION — City or To	own, State			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME	AND ADDRESS OF FACILIT	Υ					
ANDREW K. COFFMAN FUNERAL HOME, I 40 E. ANTIETAM ST., HAGERSTOWN, MI									
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): d.								
I I	PART II. Other eignificant conditions contributing to deeth but no	ot resulting in the underly	ring ceuse given in Part	i. 24a. WAS AN PERFOR		WERE AUTOPSY FINDINGS			
MEDICAL				1 TES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF CEATH?			
						1 YES 2 NO			
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26.	PLACE OF DEATH (Check o	nly one)					
YSIC	1 (2) HES 2 NO 1 Inpatient 2 ER/Outpatient			Other (Specify)					
/ PHY	27. MANNER OF DEATH 1	INJURY	INJURY AT 28d WORK?	. DEȘCRIBE HOW II	NJURY OCCURED				
ED BY	building, etc. (Specify)	t home, farm, street, factory, or		LOCATION (Street a City or Town, State)	and Number or Rural I	Route Number,			
Ē	A. CENTER								
COMPLET	(Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, one)					e) end manner se stated.			
ECC	296. SIGNAPURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) 3-14/92					
8	I dwarf with Hos		10-10	62	> 5-11	4/93			
TO B	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (1-4		050070	4/93			
8	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (I FDWARD W. DITTO 3RD M.D 31. DATE FILED (Month, Day, Your) MAR 1 (1993)	. 217 W.W	1-4		GERSTOW	<i>Y/93</i> N,MD.21740			



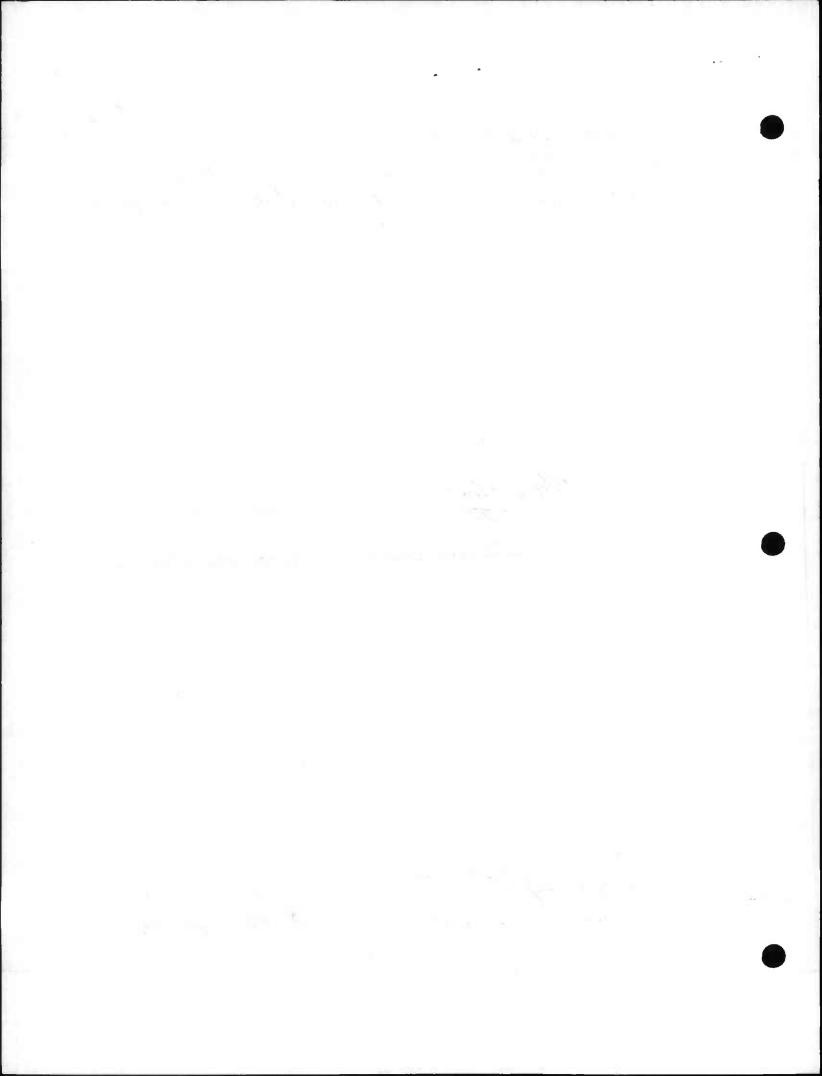
FOR

OF VITAL RECORDS, P.O. BOX 68760, N.



BALTIMORE, MARYLAND	4 hours after death. Page 6 may be retail	filled in by the funeral director, page 5 shou	in. or removal.	a madical avaminar must be notified
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospit	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	The mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked or item 23 shows any injury or other traumatic event the medical avaminar must be notified at another

	FOR 1 - STATE		STATE OF I	- Maryl							MEN	TAL HYGIEN	e 93	0	8744
	REGISTRAR 1. DECEDENT'S NAME (First	Middle Leet			Ci	EHIIF	ICAT	E OF	DEA	ТН	1	REG. NO.		La	reenued
		50,	LIAN J						,		M4	ATE OF DEATH DNTH DA 3 - 14	- 9	YEAR 5	3 196 M
	2/2 - 20-8	-	5. SEX	6. AGE	(In yrs. las	YRS.	IF UNDER	DAYS	HOURS	MIN.	7. D.	ATE OF BIRTH forith, Day, Year) 7 — 19 —	13	Country) Mary	ACE (State or Foreign land
	9a. FACILITY NAME (If not in						9b. CITY	, TOWN C	OR LOCA	TION OF D	EATH		9c. COUN	TY OF DEA	TH
5	213A S.		an			,	Her	mea	u	Ju	4		Surfacel.		el.
	RESIDENCE OF DEC	10b. COUNTY	1			10c, CIT	Y, TOWN (OR LOCAT	TION					1,	od. INSIDE CITY
- DIRECTOR	Maryland	Ha	rford Co	unty	7			deG	Grac	e, Ma	ary.	land -			YES 2 NO
FUNERAL	213 South U	nion A	venue		101. ZIP CODE 21078			78				AT COUNTRY?			
3	11. MARITAL STATUS		12. WAS DECEDER	NT EVER	N U.S. AR	U.S. ARMED 13. WAS DECENDENT OF HISPAN				NIC ORIGIN? (Specify Yes or No. 14. RACE			14. RACE -	- American Indian,	
BY F	1 Never Married 2 🖔 3 Widowed 4 Divo		FORCES?			NO				oan, Mexica D Specif	cify:			Specify: Whi	White, etc.
8	15, DEC	EDENT'S EDU	CATION		16a. DE	CEDENT'S	USUAL O	CCUPATIO	ON		T	16b. KIND OF BUS	HNESS/IND		te
H	(Specify only Elementary/Secondary (0	y highest grade 0-12)	College (1-4 or 5	+)	(G.	ive kind of Do NOT u	work done se retired.)	during mo	st of worl	ding					
기를	8 Truck Driver Trucking Industry									У					
COMPLETED	17. FATHER'S NAME (First, M											rst, Middle, Maiden			
111	Herman Juli	Julian Dixon							D	lizal	bet!	h Loller			
TO BE	19s. INFORMANT'S NAME (7				191				nd Numb	er or Rural	Route I	lumber, City or Town	, Statu, Zip	Code)	1070/
	Julian H.					PO E	Box	314	D	elawa	are	City, I	elawa	are	19706
	20a METHOD OF DISPOSITI	ION on 3 🗆 Reme	oval from State	ced	metery, cre	matory or o	OF DISPOS		me of		1	1		Ity or Town	
		GAlena Cemetery, 3-18-93 Galena, Maryland													
	William	1	Ting of L	in			F	ello	OWS		ral	Homes,		arvil a	nd 21013
200	226 E. Main St. Cecilton, Maryland 21913 23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory errest, abook, or heart failure. List only one cause on each line.														
	shock, or heart failure. List only one cause on each line. Interval Between														
	disease or condition														
2 2	DUE TO (OR AS A CONSEQUENCE OF):														
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING														
FIS	CAUSE (Disease or Inju	lry S	DUE TO	(OR AS	A CONSEC	DUENCE O	F):								
	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST														
i ö	PART il Other significa	nt condition	a anni-ib-uttan ta	diidh b											
E B	PART il. Other significa	in condition	s contributing to	death	out not r	esulting	in the un	iderlylnç	ceuse	given in	Part i	. 24s. WAS AN PERFOR	MED?	, A	ERE AUTOPSY FINDINGS MILABLE PRIOR TO
MEDICAL		-										1 TYES 2	NO		OMPLETION OF CAUSE F DEATH?
Σ														1	YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO	O MEDICAL						26 04	ACE OF	DEATH (Ch	act or	v cost			
100	EXAMINER?		HOSPITAL:	7 5000-4		□ po4	OTHER	a :	Α.				_		
Ē Ž	27. MANNER OF DEATH		28s. DATE OF		раннят з	28b. TIM		28c. INJ	_	lesidence	_	Other (Specify) DESCRIBE HOW IF	FIRM OCC	URFD	
6 1		Pending	(Month, E	Day, Ybar)	-		JURY	WO	RK?	□ NO	-			UNICO	
D BY	2 Sutates	Could not be	28e. PLACE C	OF INJURY	Y — At ho	me, farm,	street, fact				261. 1	LOCATION (Street a	nd Number	or Aural Rou	te Number.
• III		determined	building,	etc. (Spe	icity)		-					City or Town, State)	_		
COMPLET	29s. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the best of	my know	viedge, de	ath occurr	ed at the t	ime, dats	and plac	e, and due	to the	cause(s) and man	ner as state	ıd.	
OM	MEDI	CAL EXAMINE	R: On the basis of s	xaminatio	on snd/or l	investigatio	on, In my o	pinion, d	eath occ	ured at the	time,	date and place, and	d due to the	cause(s) a	nd manner as stated.
BE COI	280. SIGNATURE AND TITLE	OF CERTIFIER	Lest	Me	15/	ene	nes	Ł T	29c. LR	CENSE NUI	MBER		29d. DATE	SIGNED (M	fonth, Day, Year)
	Kuhard	1.Ca	Che MD		1				Do	7/19	4		▶ 3	1141	93
10	30. NAME AND ADDRESS OF RICHAR	D P	COLF	SE OF DE	EATH (ITE	M 27) (Type	Print) 20	13%	149	MG	Lau	waln	, NA	21	1034
12	31. DATE FILED (Month, Day,	Year)	32. REGISTRA	AR'S SIGN	ATURE				0	-		7	100		-/
1.1	MAR 17 '93 Julie Savidson-Randalle														

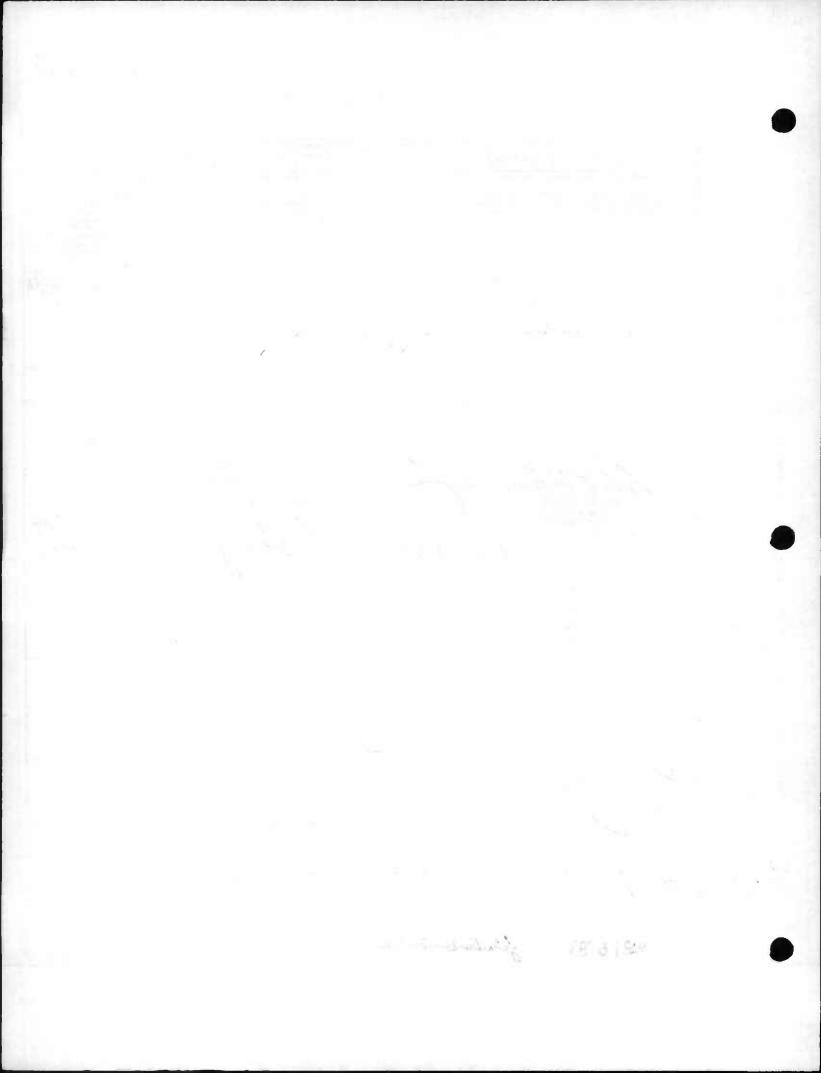


DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. FOR

	REGISTRAR		CERTIFIC	CATE OF	DEATH	R	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF			3. TIME OF DEATH		
	Mary Ellen	Diggs				MONTH 3	13	93	12:05A M		
	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF I	MRTH		IPLACE (State or Foreign		
	220-26-1633	1 🗆 M 2 🗔 🛒	62 YRS.	ONTHS DAYS	HOURS MIN.	May 9	, 1930	Countr	aryland		
OR	9a. FACILITY NAME (If not institution, give a Alice Byrd Ta	C. School St.			field, N		9c. C0	Some:			
5								DOME	. 500		
DIRECTOR	Maryland 106. COUNT	Somerset	10c. CITY,	TOWN OR LOCAT	isfield				10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO		
FUNERAL	100. STREET AND NUMBER 2982 Ape Hole Roa	ad		101.	317	10g. C		WHAT COUNTRY?			
EN I	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YE	S 2 NO	U.S. ARMED 13. WAS DECENDENT OF HISPA 2 NO 14 yes, specify Cuban, Mexico			pecify Yes or No—	14. RACI	E — American Indian, k, White, etc.		
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OF	OATES T		2 NO Speci	ly:			White		
	15. OECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S U (Give kind of wo	rk done during mos		16b. KIN	D OF BUSINESS/I	NDUSTRY			
COMPLETED	Elementary/Secondary (0-12) Grade 2	College (1-4 or 8 +)	Employee			Mrs	. Paul's	s Kito	rhen		
S O	17. FATHER'S NAME (First, Middle, Last)		21.19107		18. MOTHER'S N		e, Maiden Sumame				
BE C	William M. Diggs					Shehee					
2	19a, INFORMANT'S NAME (Type/Print)	analyton)			nd Number or Rural						
	Ruth P. Diggs (Da				b,c,d,e						
	1 St Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	constant of the control of the contr	er place)	on/Name of oate 20c. LOCATION — City or Town, State rial Park—3/15/93 Crisfield, MD						
	21. SIGNATURE OF PUNERAL SERVICE LIC	CENSEE	and I	22. NAME AN	D ADDRESS OF FA	ACILITY			THID		
	Robert H. Bra	1 - 01 - 0 - 0	4				eral Hor risfield		21817		
NO	ahock, or heart feliure. List only one cause on each line. iMMEDIATE CAUSE (Finel disease or condition resulting in death) a										
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury										
	that Initiated events OUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST										
ᄗ	PART II. Other aignificant condition	a contribution to death	but not resulting in	the medericles	enves show to	Post I av	. WAS AN AUTOPS		1		
PHYSICIAN: MEDICAL				the origenying	Cause given in		PERFORMEO? YES 2 NO	240.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
X	25. WAS CASE REFERRED TO MEDICAL			26_PL	ACE OF DEATH (C)	heck only one)					
ğ	EXAMINER? 1 VES 2 NO	HOSPITAL: 1 inpatient 2 ER/O	utpatient 3 🗆 DOA	Hursing Home	5 Residence	6 Other (Sp	ecify)				
	27. MANNER OF DEATH 1 Hatures 5 Penting 2 Accident Investigation	28a. DATE OF INJUR (Month, Day, Year	Y 26b. TIME	RY WOI	JRY AT RK? ES 2 NO	26d. OESCRI	BE HOW INJURY O	CCURED			
TED BY	2 Accident investigation 3 Suicide 6 Could not be delaphined	28e. PLACE OF INJU building, atc. (S)	RY — At home, ferm, str	eet, factory, office			N (Street and Numb wn, State)	er or Rural R	loute Number,		
COMPLETED		CIAN: To the best of my know.) and menner on stated.		
TO BE									(Month Div. Year)		
		/			Crisfie	ld, MD	21817	,			
	31. DATE FILED (Month, Day, Year) MAR 1 6 '93	DATE FILED (Month, Day, Year) 32. RECUSTRAR'S SIGNATURE									



HUI

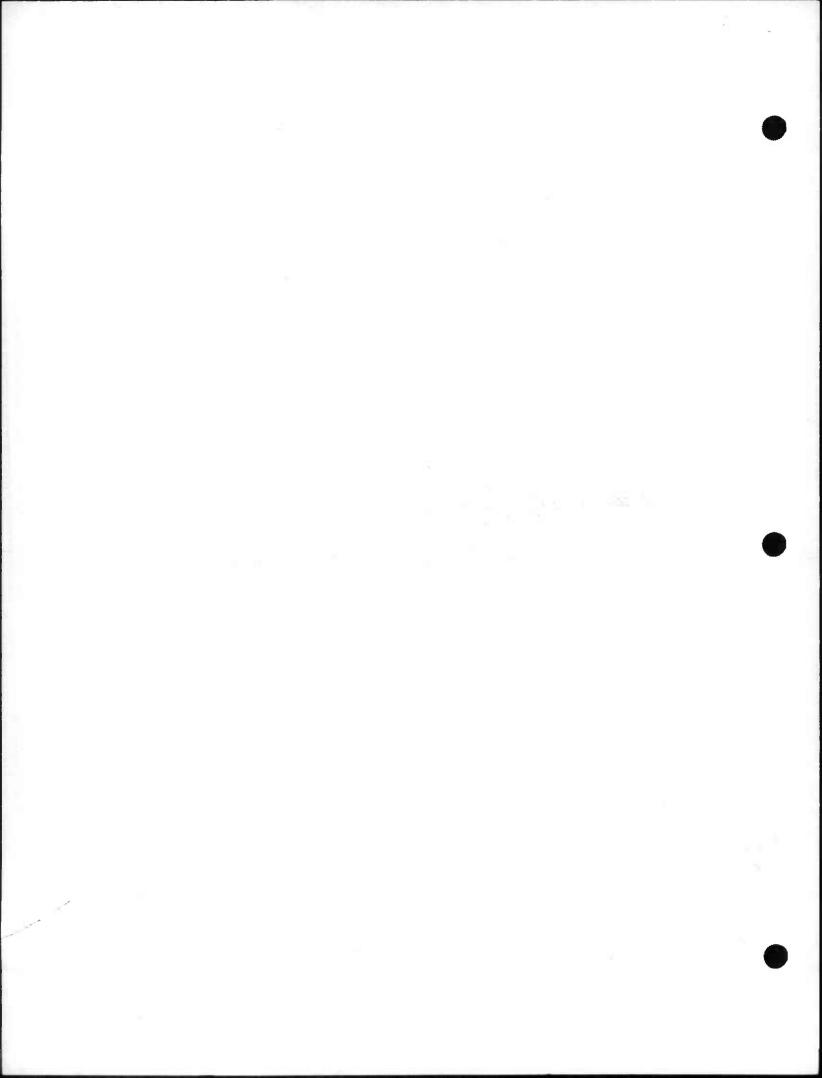
BALTIMORE, MARYLAND 21215-0020

PINE OF THIS PHYSICIAN. The Inc. CONTIN.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

	REGISTRAR		O-11111	ICATE O	PLAIR	REG. N	()				
	1. DECEDENT'S NAME (First, Middle, Last, STANLEY	Α.		DOBS		2. DATE OF DEATH		3. TIME OF DEATH			
				ממטע	ON JA.	03 16		10:54			
	4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year)	6. B	NRTHPLACE (State or Foreignantry)			
	212-58-4152	1 M 2 F	25 YRS.		200	4/04/1	0.6-	ARYLAND			
-	9a. FACILITY NAME (If not institution, give MARYLAND SHOC			BALTI	MORE.	EATH	9c. COUNTY	OF DEATH			
5	RESIDENCE OF DECEDENT			211111			CI	TY			
֝֟֝֟֝֟֝֟֝֟֝֟	10a. STATE 10b. COUN	TY	10c. CI	TY, TOWN OR LOC	ATION			10d. INSIDE CITY			
DIRECTOR	MARYLAND	CARROLL	н	AMPSTE	AD			LIMITS?			
AL	10e. STREET AND NUMBER				IOI. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?				
Ë	1222 MAIN ST.				2107	4		USA.			
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YE		13. WAS DI	CENDENT OF HISPAI	NIC ORIGIN? (Specify Y	ea or No- 14.1	RACE — American Indian, Black, White, atc.			
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OF	A DATES	1 🗆 YI	S 2 XNO Specif			Specify:			
- 1	15. DECEDENT'S ED	UCATION	NO 16a, DECEDENT'S	USUAL OCCUPAT	TION	165 KIND OF B	USINESS/INDUSTI	WHITE			
E	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4 or 5+)	(Give kind of life. Do NOT u	work done during r	nost of working	Total Killio Of B	03/11/23/11/03/1				
릴	12			UNEMPL	OYED						
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maide					
BE		THEODORE	W. DOBS	ON	PATI	RICIA AN	N BAKE	R			
	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Cod										
PATRICIA A. BERRY 19b. MAILING ADDRESS (Street and Number of Rural Route Number, City or Town, State, Zip Cool 3007 BACHMAN RD., MANCHESTER, M											
	20a. METHOD OF DISPOSITION 1 Burlai 2 Cremation 3 Rer	novel from State	20b. PLACE AND DATE	other place)		OATE 20c. L	OCATION — City of	or Town, State			
	4 Donation 5 Other (Specify)		CARROLL	CREMA		3/18/93	HAMPST	EAD, MD.			
	21. BIGNATURE OF FUNERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ELINE FUNERAL HOME										
	ELINE FUNERAL HOME 934 S. MAIN ST. HAMPSTEAD, MD. 216 23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate										
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Contactourshotwound of head DUE TO (OR AS A CONTROURNE OF)										
. 1		DUE TO (OR AS	S A COMMEQUENCE O	F):	D						
CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b	S A CONSEQUENCE O		7						
SERTIFICATION	If any, leading to immediate	bOUE TO (OR A:		F):	, D						
	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	bOUE TO (OR A:	S A CONSEQUENCE O	F):		Part I. 24a, WAS A	N AUTOPSY				
DICAL	If amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	bOUE TO (OR A:	S A CONSEQUENCE O	F):		Part I. 24a, WAS A	ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAR			
DICAL	If amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	bOUE TO (OR A:	S A CONSEQUENCE O	F):		Part I. 24a, WAS A PERFO	ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAL OF DEATH?			
MEDICAL	If amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	bOUE TO (OR AS	S A CONSEQUENCE O	F):	<i>ν</i>	Part I. 24a, WAS A PERFO	ORMED?	24b. WERE AUTOPSY FIND AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 \(\square\) NO			
MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	b. OUE TO (OR AS	S A CONSEQUENCE O	in the underlyl	<i>ν</i>	Part I. 24a. WAS A PERFC	ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAR OF DEATH?			
MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PYES 2 NO	b. OUE TO (OR AS c. OUE TO (OR AS d. OUE TO (OR AS DESCRIPTION OF TO (OR AS DESCRIPTION OF TO (OR AS DESCRIPTION OF TO (OR AS)	S A CONSEQUENCE O	in the underlying the	ng ceuse given in PLACE OF DEATH (Ch	Part I. 24a, WAS A PERFC 1 YES eck only one)-	PRMED?	AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH? 1 XYES 2 NO			
PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	oue to (or As ou	S A CONSEQUENCE OF S A CONSEQUEN	26. OTHER: 4 Nursing Hotel Dept. 28c. Williams	ng ceuse given in PLACE OF DEATH (Ch	Part I. 24a, WAS A PERFC 1 YES eck only one): 6 Other (Specify) 28d, DESCRIBE HOW	DRMED? 2 NO INJURY OCCURE!	AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH?			
PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART N. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	oue to (or As ou	s a consequence of the policy	26. OTHER: 4 Nursing Hofelor 28c. W	ng ceuse given in PLACE OF DEATH (Ch. me 5 Rasidence IJURY AT ORK? YES 2 NO	Part I. 24a. WAS A PERFC 1 X YES ack only one)- 6 Other (Specify) 28d. DESCRIBE HOW SELF-IN-	ORMED? 2 NO INJURY OCCURE! FLICTE	AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH? 1 VES 2 NO			
ED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	oue to (or As ou	s a consequence of s a consequence of the partial state of the sequence of the	26. OTHER: 4 Nursing Hofelor 28c. W	ng ceuse given in PLACE OF DEATH (Ch. me 5 Rasidence IJURY AT ORK? YES 2 NO	Part I. 24a. WAS A PERFC 1 X YES ack only one)- 6 Other (Specify) 28d. DESCRIBE HOW SELF-IN-	INJURY OCCURE FLICTE t and Number or Ru	AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH? 1 YES 2 NO D WOUND SHO			
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ED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE. (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PYES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only)	D. OUE TO (OR AS C. OUE TO (OR AS d	s a consequence of s a consequen	In the underlyl 26. OTHER: 4 Nursing Ho E OF 28c. # JURY M O PM 1 Street, factory, off	PLACE OF DEATH (Ch. me 5 Rasidence LULRY AT ORK? YES 2 NO	Part I. 24a, WAS A PERFC 1 YES sck only one)- 6 Other (Specify) 2ed, DESCRIBE HOW SELF-IN- 281, LOCATION (Sine of the Course of	PAMED? 2 NO 2 NO 2 NO 2 NO 2 NO 2 NO 2 NO 2 NO	AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH? 1 YES 2 NO D WOUND SHO THE ROUTE Number, MD / CARROL			
ED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN	D. OUE TO (OR AS	s a consequence of s a consequen	In the underlyl 26. OTHER: 4 Nursing Ho E OF 28c. # JURY M O PM 1 Street, factory, off	ng ceuse given in PLACE OF DEATH (Ch me 5 Raeldence IJURY AT ORK? YES 2 NO ica te and place, end dua death occured at the	Part I. 24a, WAS A PERFO 1 YES ack only one)- 6 Other (Specify) 28d. DESCRIBE HOW SELF-IN- 28f. LOCATION (Street No. 1) 28f. LOCATION (Street No. 1) 1. 272 2 NA. 1 to the cause(a) end m time, date and placa, i	PAMED? 2 NO 2 NO 2 NO 2 NO 2 NO 2 NO 2 NO 2 NO	AMILABLE PRIOR TO COMPLETION OF CAI OF DEATH? 1 YES 2 NO D WOUND SHO OF THE PROPERTY OF THE			
COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE. (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PYES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only)	D. OUE TO (OR AS	s a consequence of s a consequen	In the underlyl 26. OTHER: 4 Nursing Ho E OF 28c. # JURY M O PM 1 Street, factory, off	ng ceuse given in PLACE OF DEATH (Ch me 5 Rasidence IJURY AT ORK? YES 2 NO ica te and place, end dua death occured at the	Part I. 24a, WAS A PERFO 1 YES 1 YES 6 Other (Specify) 28d. DESCRIBE HOW SELF-IN- 28f. LOCATION (Street No. 1) 28f. LOCATION (Street No. 1) 1. 272 2 NA. 1 to the cause(a) end m time, date and placa, in the cause (a) and matime, date and placa, in the cause (b) and matime, date and placa, in the cause (b) and matime, date and placa, in the cause (c) and matime, date and date and date and date and date and date and date and date and date and date and date and da	INJURY OCCURE FLICTE SIN ST. anner ea stated. and dua to the cau	AMILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 X YES 2 NO D WOUND SHO Italian Route Number, MD / CARROL (CARROL (CARROL (CARROL) (CARROL (CARROL) (CARROL) (CARROL) (CARROL)			
BE COMPLETED BY PHYSICIAN: MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART N. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS (Check only one) 2 MEDICAL EXAMINERS. EXEMPLIFIED TITLE OF CERTIFIER	oue to (or As ou	s a consequence of some properties of the consequence of the consequen	26. In the underlying the street, factory, off and at the time, daren, in my opinion,	PLACE OF DEATH (Charme 5 Residence NUMPY AT ORK? YES 2 NO Ite and place, end dua death occurred at the 29c. LICENSE NUM	Part I. 24a. WAS A PERFC 1 VES 1 VES 1 VES 24c. WAS A PERFC 1 VES 1 VES 24c. WAS A PERFC 1 VES 26c. Other (Specify) 28d. DESCRIBE HOW SELF - IN - 28f. LOCATION (Street 1 VES) 28	INJURY OCCURE FLICTE t and Number or Ru IN ST. anner ea stated. and due to the cau 29d. DATE SIG	D WOUND SHO COMPLETION OF CAL OF DEATH? 1 VES 2 NO D WOUND SHO TO A RROL CA RROL (CA RROL			
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FOR STATE REGISTRAR

	1. DECEDENT'S NAME (First,		ECKAR								MONT	400		YEAR	3. TIME OF OEATH
	4. SOCIAL SECURITY NUME			8. AGE ((In yrs. lest b	irthday)	JE LINDE	1 YEAR	IE UNDE	R 24 HRS.	3 7 DATE	OF BIRTH	0	7.3	PLACE (State or Foreign
	216-05-09	68	11 M 2 🗆 F		90	YRS.	MONTHS	DAY8	HOURS	MIN.	(Mon	th, Day, Year)	, , , ,	Countr	y)
	90. FACILITY NAME (# not in				30		9b. CiT	r, TOWN	OR LOCAT	ION OF DI	JAN	. 24,	1903		RYLAND
CTOR	WESTMINST	ER NU	RSING &	CO	NV.	CTH			INS'						
ן ה	RESIDENCE OF DEC	10b. COUNT					y, TOWN			1.151/			CARROLL		
DIRE	MARYLAND	CARR													10d. INSIDE CITY LIMITS?
_	10e. STREET AND NUMBER	CERR	עעט.		TANEYTOWN 101. ZIP CODE				10g CITIZE			EN OF W	YES 2 NO		
ERAL	17 FAIRVI	EW AV	ENUE		21787				10g. CITI2						
	11. MARITAL STATUS		12. WAS DECEDENT	EVER IN	U.S. ARME	U.S. ARMED 13 WAS DECEMBENT OF HIGHAN				IIC ORIGI	N? (Specify Yes	or No-	USZ	A American Indian,	
	1 Never Merried 2 3 Nover Merried 2 Divo		FORCES? 1 [IF YES, GIVE WA	YES	2 [XINO ATES			If yes, s	S 2 NO	en, Mexice	n, Puerto	Rican, etc.)			, White, atc.
													JCASIAN		
<u> </u>	(Specify only	EDENT'S EDU highest grade	completed)	\Box	(Give	kind of w	USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY								
	Elementary/Secondery (0 6th	-12)	College (1-4 or 5+)			Me. Do NOT use retired.) AKER					Ι.				
COM	17. FATHER'S NAME (First, M.	iddle, Last)			DAN	CK			18 MOT	MED'S NA		BAKERY Middle, Maiden			
ט	CLARENCE		L. F	ECK	ARD					SA	ME (FRSI,	BELLE		0.1	
20	19e. INFORMANT'S NAME (7)	-				AILING	ADORES	S (Street		-	Route Num				HLER
임	190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 159 UNION BRIDGE, MARYLA									ND 2179					
	206. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION City of Town.										TAIL.				
	GRACE U.C.C. CEMETERY 3/24 TANEYTOWN, MARY											MARYLAN			
	21. SIGNATURE OF FUNERAL	22. NAME AND ADDRESS OF FACILITY 136 EAST BALTIMORE ST											IMORE ST		
	SKILES FUNERAL HOME TANEYTOWN, MD 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, Approximate														
FICATION	disease or condition a. A S C V D DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE)										Vocate				
	that initieted events resulting in death) LAST		d	JR AS A	CONSEQUE	NCE OF):								
MEDICAL CE	PART II. Other algorification	nt condition	s contributing to d	leath bu	ut not resu	uiting i	n the un	deriyin	g ceuse	given in	Part i.	24s. WAS AN PERFORM	MEO?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
: 11														- 1	1 YES 2 NO
CIAN	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL						26. P	LACE OF D	EATH (Che	ick only on	e)			
7 I	1 TYES 2 NO		HOSPITAL:	ER/Outpa	etlent 3 🗆		OTHER 4 Mun		ne 5 🗆 Re	eldence	8 🗆 Othe	r (Specify)			
	27. MANNER OF DEATH	30.111	28e. DATE OF IP (Month, Day)		2	8b. TIME			JURY AT		28d. DES	CRIBE HOW IN	JURY OCCU	IRED	
		Pending Investigation					М		YES 2	NO					
		Could not be letermined	28e. PLACE OF building, et	INJURY .	— At home,	ferm, at	reet, fact	ory, offic	ie .		281. LOC City	ATION (Street ea or Town, State)	nd Number o	r Rural Ro	oute Number,
<u> </u>	29e. CERTIFIER 1 CERTIFIER	EVING DUVEI	MAN: To the heat of or	. to sout	al dea										
COMPL			CIAN: To the best of m R: On the basis of exa												end menner ee stated.
	29b. SIGNATURE AND TITLE									NSE NUM					(Month, Day, Year)
2	Mm To	Lin	W A	1	8				1.1	1421	7		> 2	/20	1/4 7
2	30. MARIE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)														
	Wm. I	LI	NTHIEV		m. D:		P.	2. 6	Bey	452	IT.	ANEY	TOWA	me	1 21787
	31. DATE FILED (Month, Day)	יםי כיל	32. REGISTRAR	S SIGNA	TURE	. 30	-1.00				,				

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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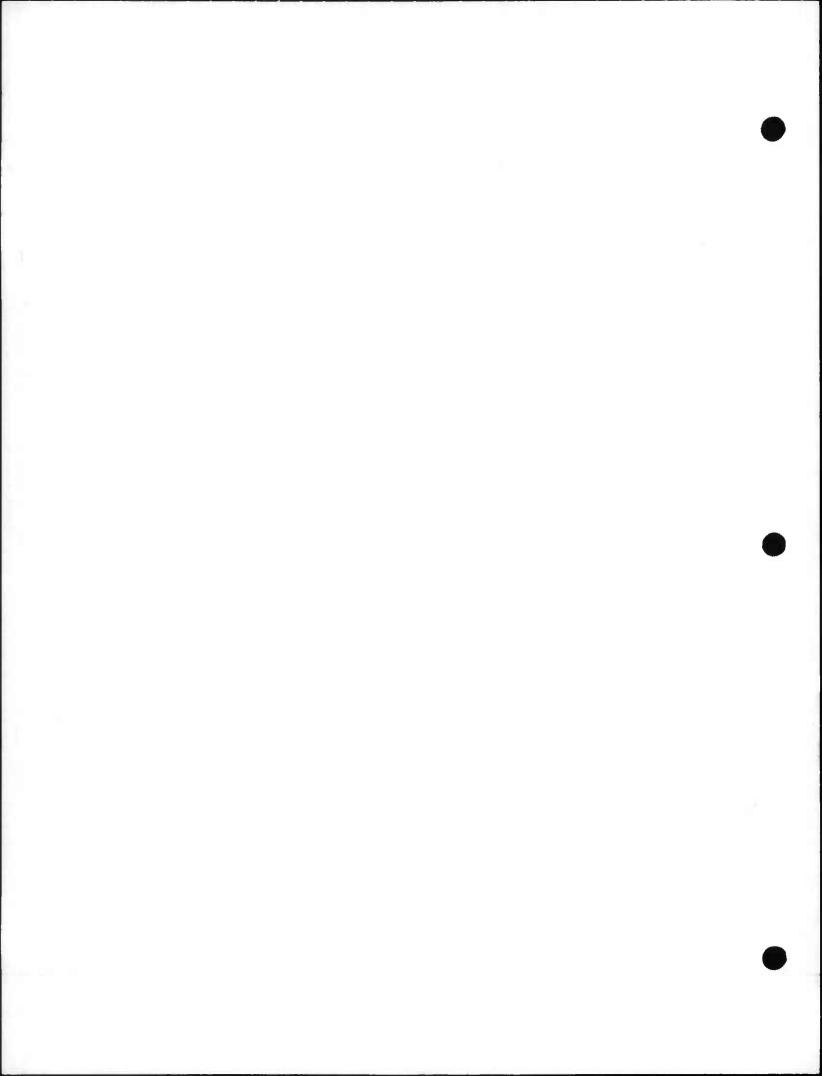
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSIDAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours, car common in State Dept. of Health and Merital Hygiens prior to burial, cremation, or removal.

IMPORTANT: If Item is formered or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

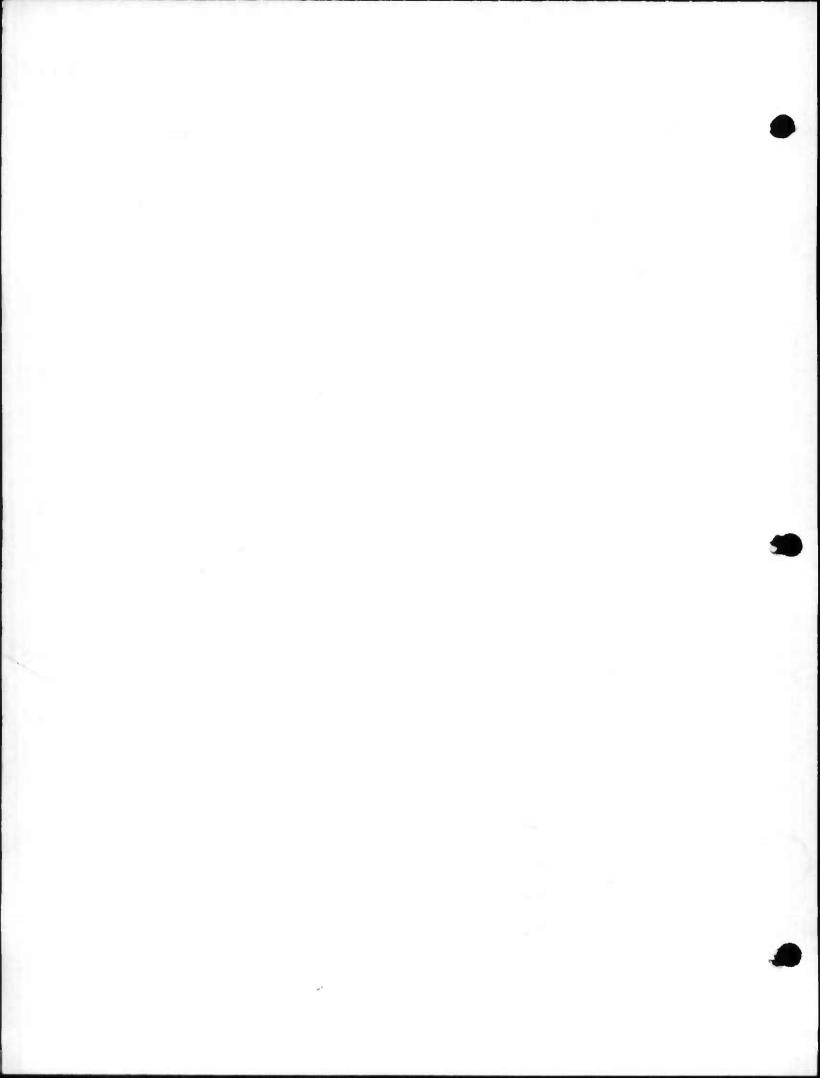
STATE	0F	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGI	ENE
		CI	ERTIFICATE	0	F DEAT	H		REG. N	NO

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HE		NTAL HYGIENE				
- 6		ELIZABETH NA	OMI EISEN	HART L	2.	DATE OF DEATH DAY	93 YEAR	3. TIME OF DEATH 4:10 am		
	577-14-7871	1 DM 2 DE 73	YRS.	DAYS F	HOURS MIN.	DATE OF BIRTH (Month, Day, Year)	19 WASH	INGTON, D.C.		
OB	9a. FACILITY NAME (If not institution, give street HOLY CROSS HOST		1		VER SPRIN		MONTG	OMERY		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCATIO			10d. INSIDE CITY			
1	MARYLAND MON'I	<u> GOMERY</u>	SI	LVER SP	RING OP CODE		LIMITS? 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	10820 GEORGIA AVEN				20902		USA			
B⊀	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DA 1942-1944	U.S. ARMED 2 2 NO	If yes, spec	IDENT OF HISPANIC of ty Cuban, Mexican, P NO Specify:	ORIGIN? (Specify Yes of verto Rican, etc.)	Black Specif	— American Indian, , White, atc. y: THITE		
ETED	16. DECEDENT'S EDUCA (Specify only highest grade co	TION ompleted)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use i	k done during most	of working	16b. KIND OF BUSH		HILLE .		
PLE	Elementary/Secondary (0-12)	mentary/secondary (U-12) College (1-4 or 5+)				AMERICAN	SECURIT	Y&TRUST		
COMPL	17. FATHER'S NAME (First, Middle, Last)			1	IS. MOTHER'S NAME	(First, Middle, Maiden Sc		20211002		
BE	CHARLES G. EISENHA 19a. INFORMANT'S NAME (Type/Print)		Verring	EDNA N.						
5	EDNA JANE RUPPRECH	НТ		DELIVE		ON, MARYLA		27		
	20a. METHOD OF DISPOSITION 1 Description Method Description Descri	206	PLACE AND DATE OF	DISPOSITION (Name	oof	DATE 20c. LOCA	ATION — City or Tox	vn, Stata		
	Surfal 2 Cremation 3 Removal from State Commetter, crematory or other place ROCK CREEK CEMETERY 3/15 WASHINGTON, D.C.									
	> Steven ?	Strong		500 UN	IVERSITY	BLVD.,W.	SIL.SPR.			
	23. PART I. Enter the diseases, or con shock, or heart fellure. List	mplications that ceused st only one ceuse on e	the death. Do not ech line.	enter the mode	of dying, such as	s cardiec or reapire	story arrest,	Approximate Interval Between		
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Metastatic Papillary Carcinoma Hyroid Onset and Death Onset and Death									
NOI	Sequentielly llat conditions, b									
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury) that initiated eventa DUE TO (OR AS A CONSEQUENCE OF):									
CERT	resulting in death) LAST									
ICAL	PART II. Other significent conditions	contributing to death be	ut not resulting in	the underlying o	ceuse given in Par	1 I. 24a. WAS AN AI PERFORM	ED?	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE		
HYSICIAN: MEDIC						-		OF DEATH? 1 YES 2 NO		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PLAC	E OF DEATH (Check	only one)	1			
HYS	1 YES 2 NO 1 27. MANNER OF DEATH	26e. DATE OF INJURY		☐ Nursing Home		Other (Specify)	IUDY OCCUBED			
à	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	WORK	37 S 2 NO					
ETER	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, atc. (Spec	At nome, farm, stre	et, nactory, omca	26	1. LOCATION (Street and City or Town, State)	d Number or Rural Ru	oute Number,		
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:							and manner as stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month). Day, Year) 29d. DATE SIGNED (Month). Day, Year)									
TO	980 / GCESIS AND, SI/VEL SPINS MD 20902									
	MAR 16 93	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE								



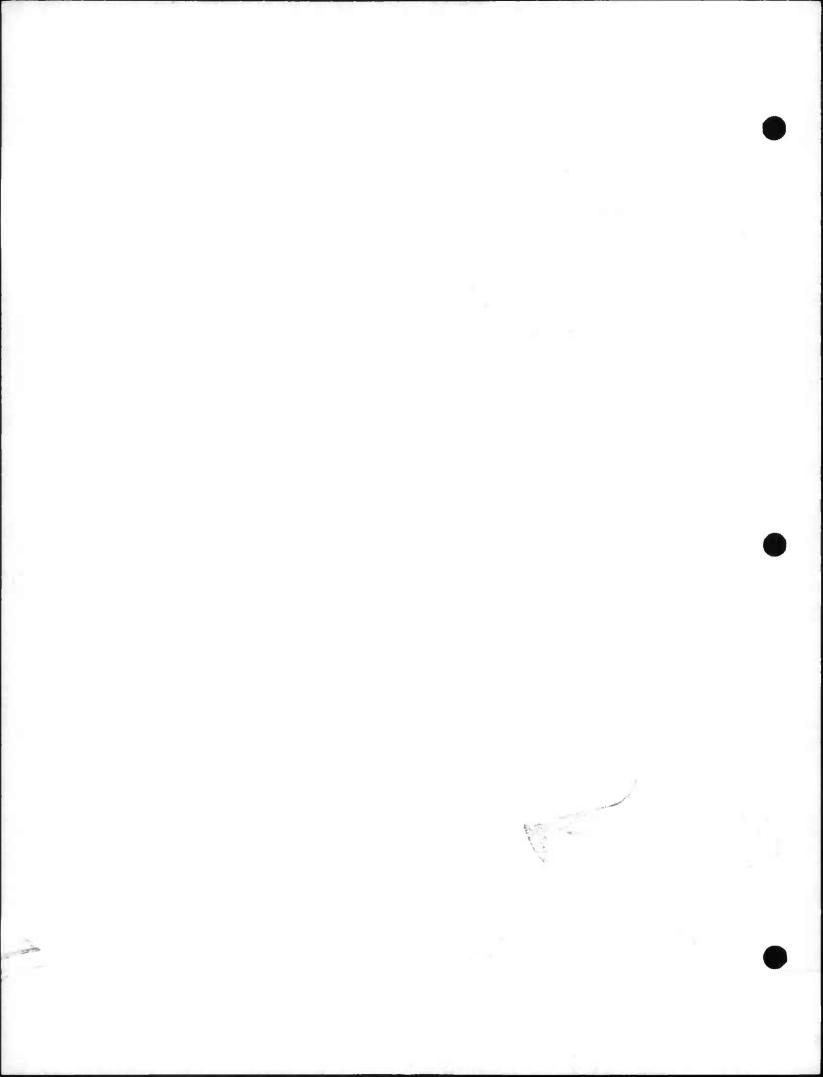
	PATENDING PHYSICIAN: The law requires that the death certificate be executed within with a ster death. Page 6 may be retained by the hospital or attending physician.	IEP DIRECTOR: After this certificate has been signed by the attending physician and completely miled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
ארוכיססוף, שיחוורה, אוריים לונסיים אוריים	spital or att	ed for use
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<u>.</u>	e 6 may b	ector, page
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	AN: The	ificate ha
5	PHYSICL	this cert
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	TIN HIT	DIRECTO
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		FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF		MENTAL HYGIEN REG. NO.	E SM)	page 6	
		1. DECEDENT'S NAME (First, Middle, Last)	ENGI			Engel	2. DATE OF DEATH DO	93	1037. 11	
2		4. SOCIAL SECURITY NUMBER 076-30-4899	1 [X M 2 □ F 55	yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS			0	emmerace (State or Foreign Sustria	
2, 3 should	TOR	99. FACILITY NAME (If not institution, give str Hebrew Home of Gre RESIDENCE OF DECEMENT		ton	Rockvi	or location of de	ATH	MOVE	SF DEATH SOMEY	
46 physician. burlat-transit permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY	gomery		y, TOWN OR LOCA CKVille	ATION		-	10d. INSIDE CITY LIMITS? 1 YES 2 X NO	
nsit permit	FUNERAL	10a. STREET AND NUMBER 6121 Montrose Roa			10	01. ZIP CODE 20852	2		of what country? States	
MARYLAND 21203-3146 retained by the hospital or attending physician. 5 should be detached for use as the burial-tran notified at once.	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 NO	If yes, s	CENDENT OF HISPAN pecify Cuben, Mexicer S 2 NO Specify	IC ORIGIN? (Specify Year, Puerto Ricen, etc.)		RACE — American Indien, Bleck, White, etc. Specify: White	
21203-3146 pital or attending phys of for use as the buri	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementery/Secondary (0-12)		(Give kind of life. Do NOT un		ION lost of working	SINESS/INDUST			
MARYLAND 21 s retained by the hospital of 5 should be detached for notified at once.	BE COM	17. FATHER'S NAME (First, Middle, Last) Ludwig Engel		Surname)						
, MARY be retained to age 5 should be notified	TO E	199. INFORMANT'S NAME (Type/Print) Katerina E. Alter		9220	0910					
BALTIMORE, I er death. Page 6 may be the funeral director, page val.		20b. PLACE OF DISPOSITION 1 Burlet 2 X Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place) Suburban Crematory 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22c. LOCATION — City or Town, State other place) Suburban Crematory 22c. LOCATION — City or Town, State other place) Suburban Crematory 22c. LOCATION — City or Town, State other place) Suburban Crematory 22c. LOCATION — City or Town, State other place) Suburban Crematory 22c. LOCATION — City or Town, State other place) Suburban Crematory 22c. LOCATION — City or Town, State other place) Suburban Crematory 22c. LOCATION — City or Town, State other place) Suburban Crematory 22c. LOCATION — City or Town, State other place) Suburban Crematory 22c. LOCATION — City or Town, State other place) Suburban Crematory 22c. LOCATION — City or Town, State other place) Suburban Crematory 22c. LOCATION — City or Town, State other place) Suburban Crematory 22c. LOCATION — City or Town, State other place)								
		· Elsen 4	V. Rapy)	933	Gist Aver	nue, Silve	r sprin	ng, MD 20910	
within burs a within burs a repetely mind in b recreation, or in		23. PART I. Enter the diseases, or conshock, or heart fellure. Limited the constant of the con	let only one cause on and	consequence of	Enc	ephal	opathy	Iratory arrest,	Approximate Interval Between Onset and Death	
. O. BOX 13: n certificate be execunding physician and Hygiene prior to bur	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that infiltated events resulting in desth) LAST	DUE TO (OR AS A C	ONSEQUENCE O	(Of)W	munar use	y /Trr	28/		
RECORDS w requires that the peen signed by the rt. of Health and M shows any inje	MEDICAL	PART II. Other significant conditions	Adizop	1	In the underlyli	ng cause given in	Part I. 24a. WAS AN PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
TAL The The hare ha	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpat	lent 3 🗆 DOA	OTHER:	PLACE OF DEATH (Che				
OF PHYSIC this ce with th	B	27. MANNER OF DEATH 1 Netural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY -		M 1 🗆	JURY AT YORK? YES 2 NO	28d. DESCRIBE HOW 28f. LOCATION (Street			
ATTENDING PINECTOR: After Cours after deatt	COMPLETED	3 Suicide S Could not be determined	building, etc. (Specify	0			City or Town, State)		
TO THE COSPORED TO THE PROPERTY.		anal (1	R: On the beele of examination				time, date end place, er	nd due to the ca	use(e) end menner as stated.	
55 55 50 MI	TO BE	30. NAME AND ADDRESS OF PERSON WHO	- JENT			D 18	084	>371	4/93	
4		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	TURE	Hise	e Kelf	Lockville	e MI	120852	
		MAR 16 '93	Julia Davids	m-fandel	2					



ATENDING PHYSICIAN: The law requires that the death certificate be executed within 2	C	-
or SHOWS PHYSICIAN: The law requires that the death certificate be executed to the Albir this certificate has been signed by the attending physician and control of the attend	within	pletely
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A ENDING PHYSICIAN. The law requires that the death certificate by EGIPR. After this certificate has been signed by the attending physicia	8	E .
ECT PROMINE PHYSICIAN: The law requires that the death certificate to the stending physical p	ă	Sicia
ECT PROBLEM PHYSICIAN: The law requires that the death certificate has been signed by the attending	Fcat	phy
ATENDING PHYSICIAN: The law requires that the death	certil	Build
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ATEMBING PHYSICIAN: The law requires that it ECTAR. After this certificate has been signed by	he	the
ATENDING PHYSICIAN: The law requires the ECTAR After this certificate has been signed	lat	5
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		1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	33	1. DECEDENT'S NAME (First, Middle, Last) Grace A. Edward Grace A. Edward 7 1/92 (2:31	TH Рм									
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7 PRS. 6. AGE (In yrs. last birthday) 7 PRS. 6. AGE (In yrs. last birthday) 7 PRS. 7 DAYS HOURS MIN. 7 DAYS HOURS MIN. 7 DAYS MIN.	Foreign									
2, 3 should	OR	98. FACILITY NAME (II not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH TO Kerner Park Me Land II Shorts	gomer									
	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Collings Colling										
sit permit. Pages		104. STREET AND NUMBER 109. CITIZEN OF WHAT COUNTRY?										
-0020 ling physician. the burial-transit	BY FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American Ind 15. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 16. RACE — American Ind 16. RACE — American Ind 17. Wildowed 4 Divorced 17. Wildowed 4 Divorced 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— 18. RACE — American Ind 18. RACE — American										
21215 al or attend for use as	ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) Homemaker	n									
MARYLAND 2 retained by the hospital 5 should be detached to notified at once.	BE COMPL	17. FATHER'S NAME (First, Middle, Last) S.T. Thambakara 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sornakili										
E, MARN y be retained to age 5 should be notified	٥	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Jeyakody Edward 6010 43rd. St. Hyattsville, Maryland 20781										
MORE, age 6 may be director, page		20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION - City or Town, State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 3/15/93 Brentwood, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE										
BALTIMORE, after death. Page 6 may be by the funeral director, page moval.		11800 New Hampshire Ave. Silver Spring	Home,Md.									
in 24 hours ely filled in thation, or re-		23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Actual MyoCan drad Infants for a cause of the	Between									
DX 687(be executed cian and corrior to burial, raumatle ex	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (DR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
end in	CERTIFI	CAUSE (Disease or injury that initiated events resulting in death) LAST										
RECORDS requires that the d been signed by the t. of Health and Mer shows any injur	MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY AMAILABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2	R TO CAUSE									
VITAL CIAN: The law ritificate has he State Dept or Item 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 NO YES 2 NO 26. PLACE OF DEATH (Check only one) OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)										
ION OF VITA IDING PHYSICIAN: The Chin this certificate h marked, or item	ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 28e. DATE OF INJURY (Month, Day, Veer) 28b. TIME OF INJURY WORK? 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED										
SICONO SI	ETED	3 Suicide 6 Could not be determined 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 26e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 26f. LOCATION (Street and Number or Pural Route Number, City or Town, State)										
	COMPLI	29a. CERTIFUNG PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated. MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner estated.	stated.									
TO THE TO THE Be filed	TO BE	296. BICHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) \$\frac{1}{3} \ll \left(9 \)\$)									
		James S. Tzeng, M.D. 7610 Carroll Ave. #400 Takoma Park, Maryland 20912										
		31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Fina Davidson Pandall										

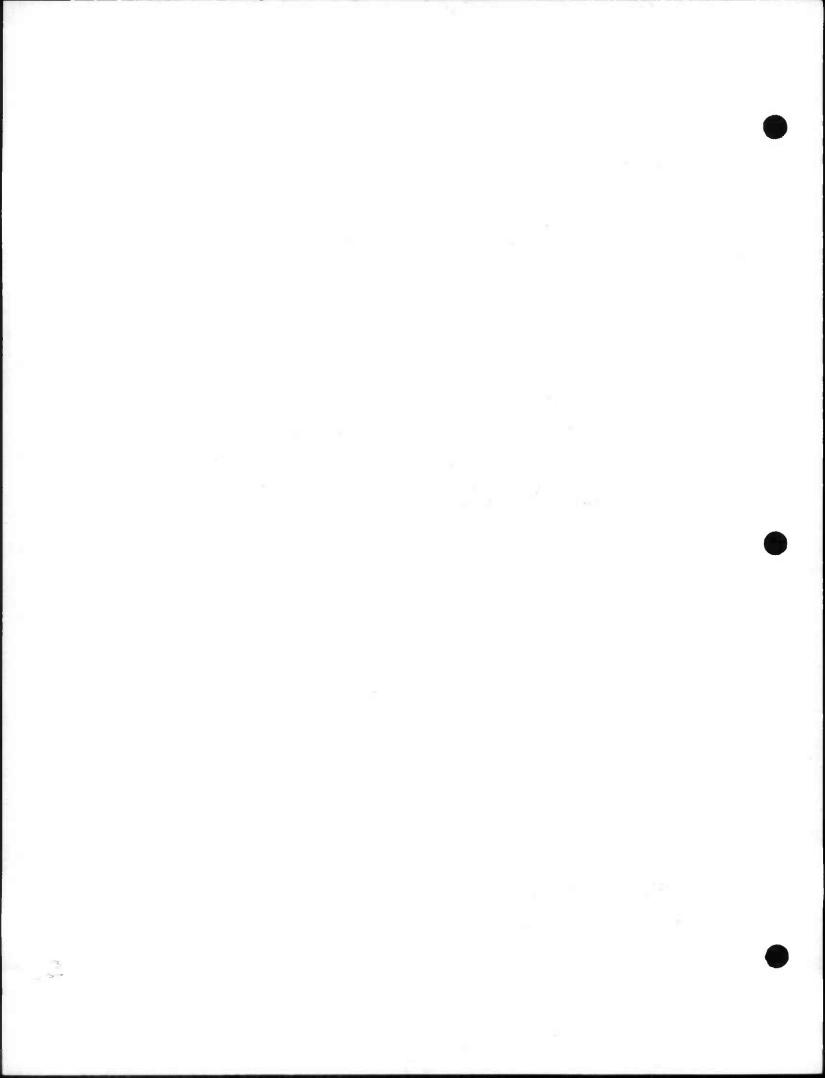


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•		Willia 4. SOCIAL SECURITY NUMB 214-36-403	ER			rs. last birthday)	Edward F UNDER 1 YEA MONTHS DAY	IF UNDER 24 HI	0 3	F OF BIE	15 27H	1993	6:45 P.
pinou		9a. FACILITY NAME (If not ins		1 M 2 F		YRS.		N OR LOCATION O		ne 6	,1938	COUNTY OF	Wash., D.C.
2,	топ	4710 Beth	nesda	Avenue,	Apt	t.703		hesda				ontgo	
t. Pages	DIRECTOR	10a. STATE MD	Mon:	tgomery			ry, Town on Lo thesda	CATION					10d. INSIDE CITY LIMITS? 1 2 YES 2 NO
t permi		10e. STREET AND NUMBER						101. ZIP CODE	,		10g.		WHAT COUNTRY?
death. Page 6 may be retained by the hospital or attending physician. If funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, all. Examiner must be notified at once.	FUNERAL	4710 Bethes	da Av	enue	20814 S. ARMED 13. WAS DECENDENT OF HISPAN				USA			E - American Indian,	
nding phys as the buria	B	1 Never Married 2 3 Wildowed 4 Divor	rced			S	II yes,	apecify Cuban, Me ES 2.4 NO S	exican, Puert				ck, White, etc.
or atte	ETED		highest grade		.16		Work done during se retired.)		1	6b. KIND	OF BUSINESS	S/INDUSTRY	
rospital iched fo	COMPLET			5		Bro	ker			Rea	l Esta	ate	
d by the I	ш	17. FATHER'S NAME (First, Mil William Wy		dwards				18. MOTHER'S	ma Te		Maiden Surnar	ne)	
5 shoul	TO B	Geoffrey P		ards				Rd., Cl				2081	5
r, page		20a. METHOD OF DISPOSITION 1 ☑ Burlel 2 ☐ Cremation	ON			ACE AND DATE	OF DISPOSITION	(Name of	0/		20c. LOCATIO		
directo		4 Donation 5 Other	(Specify)		Pa	rklawn		al Park		/19		ille,	MD
death. F funeral		Danie D	- 0	8. M.)			ph Gawle			-		n,DC 20016
ompletely al, cremat		23. PART I. Enter the dis shock, or he IMMEDIATE CAUSE (Find disease or condition resulting in death)	ert renure.	a. Andrew	on each	line.	CAMIC	node of dying,		•		arrest,	Approximate Interval Between Onset and Death
	CERTIFICATION	Sequentially list conditions, if sny, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): C. OUE TO (OR AS A CONSEQUENCE OF):											
requires that the open signed by the of Health and Me shows any Inju	MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 S 2 NO 24b. WERE AUTO AMAILABLE P COMPLETION OF DEATH? 1 YES 2									b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	SICIAN	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:			26. OTHER:	PLACE OF DEATH	(Check only	one)			
SICIAN: certific h the S	PHYS	1 VES 2 □ NO 27. MANNER OF DEATH		1 Inpatient 2 E	JURY	28b. TIM	4 Nursing H	ome 5 Residen			HOW INJURY	OCCURED	
DING PHYS After this of death with	ВУР	1 Natural 5 P 2 Accident Ir	Pending nvestigation	(Month, Day,	50		M 1	WORK? YES 2 NO					
28 L	ETED	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 281. LOCATION (Street and Number or Rural City or Town, State)									Route Number,		
Mary and	COMPLE			CIAN: To the beat of my									a) and manner as stated.
TO THE HOSPITA TO THE BAREPA De field within T	BE	SHE SHINATURE AND TITLE	OF CERTIFIER	Marie				29c. LICENSE			29d.		(Month, Day, Year)
₽₽%.	2	30. NAME AND ADDRESS OF	PERSON WHI						.M.E				6/1993
		31. DATE FILEO (Month, Day, W		32. REGISTRAR'S	SIGNATU	RE	n Stre	eet, Ba	ltim	ore	, Mar	ylan	d 21201
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HEATH OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be made after the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

- ()	1. DECEDENT'S NAME (First,	, Middle, Last)						DLA		2. DATE OF DEATH	J		3. TIME OF DEATH	
12	Walter Pankin Har Year										N-			
	4. SOCIAL SECURITY HUME	5. SEX 8. AGE (In yrs. last birth			IF UNDER		IF UNDE	R 24 HRS.	03 04 1993 7. DATE OF BIRTH 8. BIRT			5:45 A M HPLACE (State or Foreign		
- 1	578-38-1696	1 🖾 M 2 🗌 F	67	7 YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) 05-06-192	5	Count	vland		
	9a. FACILITY NAME (If not in		9b. CITY	r, TOWN	OR LOCAT	OH OF DE		_	UNTY OF C	4				
NO NO	7910 Pinew	CI	07.1											
DIRECTOR	RESIDENCE OF DEC				eorge's									
H	1945	10b. COUNTY			TY, TOWN		TION					10d. INSIDE CITY LIMITS?		
۵	Maryland 100. STREET AND NUMBER	Prince	<u>e George</u>	S	C1	into					1 🗆 YES 2 🗔			
FUNERAL	The same of the state of the same of the s		•				10	f. ZIP COD	E	10g. CITIZEN OF WH				
뿐	7910 Pinewoo	od bri	VE 12. WAS DECEDEN		10 40450				20735			United States		
	1 Never Married 2 🔀	XXYES 2	2 NO			13. WAS DECENDENT OF HISPANII If yes, specify Cuben, Mexicon			es or Ho-	14. RACI Blac	14. RACE — American Indien, Black, White, etc.			
ВҰ	3 Widowed 4 Divo	rced	IF YES, GIVE Y World Wa		ES 1 ☐ YES 2 🔯 NO S¢					r.		Spec	"y: White	
8	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working.) 16b. KIND OF BUSINESS/INDUSTRY													
COMPLETED	Elementary/Secondary (0		College (1-4 or 5		(Give kind of ife. Do NOT u	work done se retired.)	during mo	local of working				02	1	
I I	12		5+	St	eam E	r			Steam			Union		
8	17. FATHER'S HAME (First, M.	liddle, Lest)						18. MOT	HER'S NA	ME (First, Middle, Maide				
BE	Harry B. E							Gr	ace	Carr				
2	19e. IHFORMANT'S NAME (7)	ype/Print)			19b. MAILIH	ADDRES	S (Street e	nd Numbe	r or Rural F	loute Number, City or To	wn, State, Z	ip Code)		
	Ruth H. Ear	_			910 E	inew	bood	Driv	re, C	Clinton, M	aryla	and	20735	
	20e. METHOD OF DISPOSITI	n 3 🗆 Remo	oval from State	cemetery, o	E AND DATE	other place)				1	OCATION -			
1	Commettery Commetter Commettery Comm													
	///	1/	+ C	+		- 1				Lee ru	neral	. Hom	e, Inc.	
	Losen	Loc	XSLOS)	the		60	633	Old .	Alexa	ander Fer	ry Ro	l.,Cl	inton,Md.	
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reapiratory arrest, Approximate													
	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Daeth													
	disease or condition resulting in death)													
	DUE TO (OR AS'A CONSEQUENCE OF)													
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CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING													
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듄	resulting in death) LAS	T L	Ch.	XXXX C	, (2	. /~	10/		1,000	01	ine o		
	BARY II Other simulfica				- 0	100	21 1		NYC	2007	00		5	
EDICAL	PART II. Other significan	nt conditions	contributing to	death but not	resulting	in the un	iderlying	g cause (given in i	Part I. 24a. WhS A PERFO	RMED7	248	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO	
ă	- 11	160	4/2	mio	-					1 □ YES 2XQ¥10			OF DEATHY	
Σ	-									_			1 YES 2 NO	
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PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		02200	OTHER	R:			ck only only				
¥ ∥	1 TYES 25 HO		1 C Impatient 2 C		-			_	raidence I	6 Chiter (Specify)				
		Pending	(Month, D		286. TIN	IURY		RK7	1	384. DESCRIBE HOW	WINNEY OC	CURED		
B	3 Control of	nvestigation	28s. PLACE O	F INJURY ALL	M 1 YES 2 NO At home, farm, street, factory, office 28					281. LOCATION (Street and Number or Sund Bouts Number				
	Control of the contro	Could not be setermined	building,	etc. (Specify)			ery, onner		- 1	City or Town, State):	ICOCHURK F	ROLITE MUMICIES	
9	SAL ASSESSED													
COMPLET	(Check only 18 SEERTHYHIG PHYSICIAM: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 295, SIGNATURE AND TITLE OF CERTIFIER													
BE	1							29c. LICI	HSE NUM	BER	29d. DA	TE SIGHED	(Month, Day, Year)	
2		PERSON WHO	COMPLETED CAUS	SE OF DEATH OF	EM 27) (Se-	Orint'		0.	711	20		3/1	193	
	Moti L. Koul, M.D., 3710 Riveria Street, Suite 2C, Temple Hills, Md. 20748									20748				
	31. DATE FILED (POPI), Day,)	Ybar)	32. REGISTRA	R'S SIGNATURE	9-0-		JUL	20	, 10	***FTC 11TT1	D, IVE	۷. ۷	.0740	
	31. DATE FILM ARR. OF.	9 1993	Julia	R'S SIGNATURE	Mande	02								
						_								

1993 EAR

9c. COUNTY OF DEATH

Montgomery

3. TIME OF DEATH

6:50A

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 YES 2 NO

8. BIRTHPLACE (State or Foreign

CANADA

10g. CITIZEN OF WHAT COUNTRY?

USA

Specify:

WHITE

2. DATE OF DEATH

1 - STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

SION OF VITAL RECORDS, P.O. BOX 68760.

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24 hours after death	
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law requires that the death certificate be executed within 24	
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30. NAME AND ADDRESS OF PERSON

Osanne -31. DATE FILED (Month, Day, Year)
MAR 19 93

ELDON LEWIS EAGLES 03"- 14 DAY Eldon L. Eagles 4. SOCIAL SECURITY NUMBER 5, SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 1 M 2 - F DAYS 03 = 09-1911 190-32-7876 82 page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give str 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Olney Montgomery Ceneral Hospital 10c. CITY, TOWN OR LOCATION MD MONTGOMERY SILVER SPRING FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 3703 BLOOMSBURY COURT 20906 age 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No If yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED If yes, specify Cuben, Mexican, I FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 XNO 1 Never Married 2 Married BY 3 🗍 Widowed 4 📗 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 5+ DOCTOR PUBLIC HEALTH 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at COMFORT EAGLES BE FLORENCE LEWIS 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 **EAGLES** 3703 BLOOMSBURY COURT SILVER oq 20a. METHOD OF DISPOSITION
1 A Burtal 2 Cremetion 3 Ren 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must director, 4 Donation Other (Specify) PARKLAWN CEMETERY 3/19 examiner 21. SIGNATURE OF 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. removal. 500 UNIVERSITY BLVD., W. SIL. SPR medical 23. PART i. Enter the diseases, or cor In by cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lis 0 IMMEDIATE CAUSE (Final i and completely filled to burial, cremation, c 鲁 disease or condition_ SCARMIC cialitis resulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF PHYSICIAN: MEDICAL CERTIFICATION Sequentielly list conditions, OUE TO (OR AS A CONSEQUENCE OF): the attending physician a Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 6 been signed by the atter pt. of Health and Mental 3 shows any injury, o PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i, 24a. WAS AN AUTOPSY Cardiomyophthi 1 TYES 2 NO NIDDOM hemodialypis Progressive renal failure regunin Dept. the State D 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? OTHER: Inpatient 2 ER/Outpatient 3 DOA ng Home 5 - Residence 8 - Other (Specify) 4 - Nurs marked, or 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED Met c 1 Natural 2 Accident 5 Pending Investigation 1 YES 2 NO BY Affer TO THE HOSPITAL OF ATTENDING TO THE FONESAL DIRECTOR, And be filed within 22 hours after deal IMPORTANT. If them 28 is mi 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide COMPLETED 6 Could not be 4 Homicide determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occursed at the time, date and place, and due to the cause(a) and manner as stated. 290. SIGNATURE AND THE OF CHATTE 29c. LICENSE NUMBER BE 04320

D COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) Blank Faid, my 3305 N. Leistre world

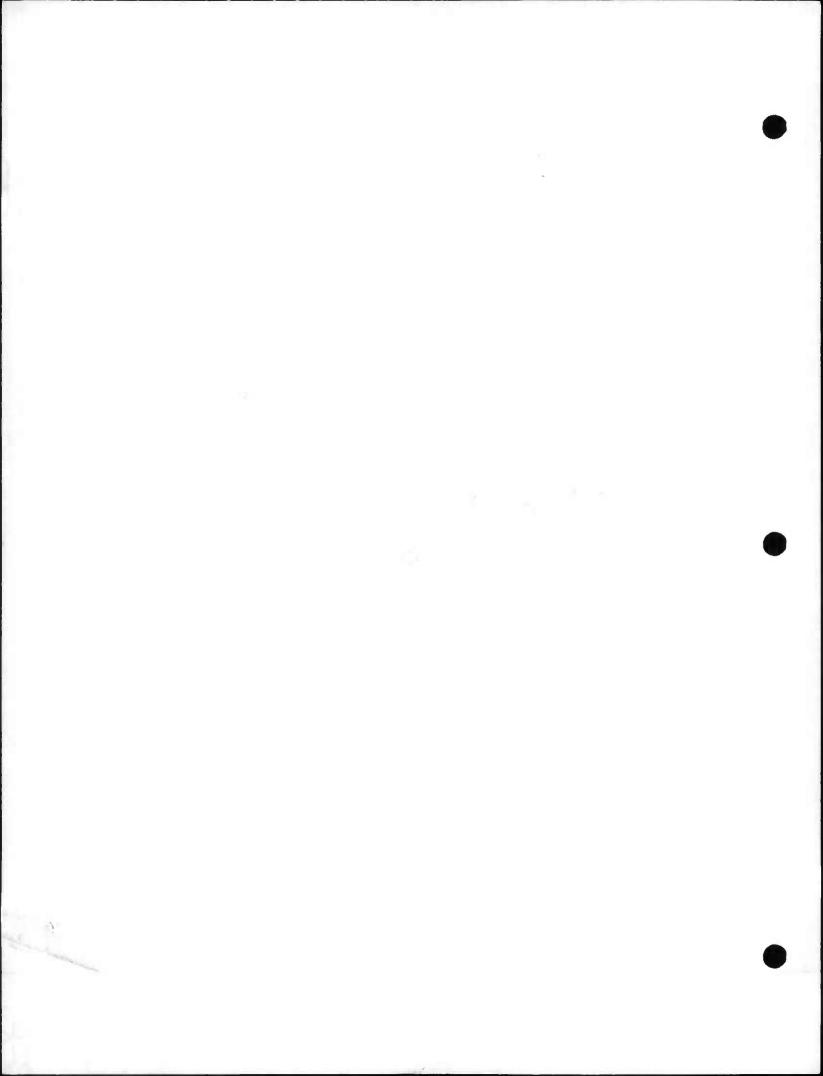
whia Davidson Randage

32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

SPRING.MD. 20906 20c. LOCATION — City or Town, State ROCKVILLE, MARYLAND Approximata Interval Bety Onset and Death 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) 3-14-93 DHMH-16 Rev 1/89



THE HOS TALL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-bransit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burlat, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

_	TIEGISTIAN				CENTIF	ICATE	UF	DEA	П		REG. NO.			
	1. DECEDENT'S NAME (First,		Mary Lo	uise	EADEI	?				2. DATE OF MONTH Feb.	D/	1993	YEAR	3. TIME OF DEATH 9:30 A. M
	4. SOCIAL SECURITY NUME	BER	5. SEX	8. AGE (In y	rs. lest birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF		-///	A BIRTI	IPLACE (State or Foreign
	215-20-9181		1 M 2 DE	7		MONTHS	DAYS	HOURS	MIN.	(Month, De	ny, Ybar)		Count	ry)
) '''					April	5,			aryland
_	9a. FACILITY NAME (If not in					9b. CITY	, TOWN	OR LOCATI	ON OF OE	EATH		9c. COU	NTY OF C	HAB
DIRECTOR	3504 Ke	emptown	n Church	Rd.			Mo	nrovi	La			F	rede	erick
5	RESIDENCE OF DEC													
<u> </u>	10a. STATE	10b. COUNT	Υ		10c, CIT	Y, TOWN	OR LOCA	TION						10d. INSIDE CITY
اۃ	Maryland	Fre	ederick		1	Mc	nro	ທຳລ						LIMITS?
	10e. STREET AND NUMBER		34.02.20.0	-		110		F. ZIP COD						
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FUNERAL		Subrom	n Church	na.				217	770				US	5A
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S	S. ARMED					IC ORIGIN? (S		or No-	14. RACI	E — American Indian, k, White, etc.
	1 Never Married 2		FORCES? 1	AR OR DATES	S MINO			ecity Cube		n, Puerto Rice	n, etc.)		Black	k, White, etc.
À	3 Widowed 4 Divo	orced						- Chair	opouny			- 1	Spec	White
		EDENT'S EDU		164	a. DECEOENT'S	USUAL O	CCUPATI	ON		16h KII	NO OF BUS	SINESS/IND		
F		y highest grade			(Give kind of life. Do NOT u	work done	during mo	ast of working	ng	l loca Kill	10 01 000	///L33//MD	OSTAT	
ן ב	Elementary/Secondary (0	1-12)	College (1-4 or 5 a)							0	1		
COMPLET	/				лоп	ısewi	.ie				_	home	-	
8	17. FATHER'S NAME (First, M							18. MOTI		ME (First, Midd				
u l	Fult	on Day	<i>r</i> is						Magg	gie B.	Core	dell		
20	19a, INFORMANT'S NAME (7	ype/Print)			19b. MAILING	ADDRESS	S (Street a	nd Number	or Rural R	Route Number, (City or Town	State Zin	Codel	
2	George H	L. Eade	ماذ		3504	Kemr	t our	n Chi	mah	PA 1	M na	1, Olalo, 2.lp	7/6-3	21770
									II CII	-	_			
	20a. METHOD OF DISPOSITI		oval from State	20b. PL	ACE AND DATE	OF DISPOS	SITION (N	ame of	,	OATE		CATION —		
	4 Donation 5 Other				Provide	nce	Met.	n.	2/2	26/93	Ke	empto	wn,	Md.
	21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE					ND AODRE						
	►/()//·	4	110	+/						sworth	*			
	Ullin	di	Mollan	alh	_	2	640	l Rid	lge F	Rd., Da	amaso	cus,	Md.	20872
	23. PART I. Enter the di shock, or he	lseeses, or c eart fsilure.	complications that List Dnly one cau	caused the	a death. Do i	not enter	the mo	de of dy	ng, such	h aa cardiac	or respi	ratory arr	est,	Approximete interval Between
	IMMEDIATE CAUSE (Fin	nal	a 1		V	1	0	1 0	1-					Onset and Death
	disease or condition	→	· Lest	him	na Va	1/10	1	1-0	184	Sol				121/m
			OUE TO	OR AS A CO	NSEQUENCE O	Đ:	-							1
z			Mad	that	* 00	In	13	4						10 years
HIFICATION	Sequentially list conditi if any, leading to immed		DUE TO	OR AN A CO	NINEQUENCE O	F):	4-6	~						
₹	cause. Enter UNDERLYI	ING												1
Ĭ	CAUSE (Disesse or Inju that initiated events	iry	c. OUE TO	(OR AS A CO	NSEQUENCE O	n:								
≣	resulting in death) LAS	r I				,								İ
			d											
	PART II. Other significa	nt condition	s contributing to	death but r	not resulting	in the un	derivin	n Cellse (iven in I	Part I 24	. WAS AN	Alimpey	246	. WERE AUTOPSY FINDINGS
EDICAL											PERFOR		240	AVAILABLE PRIOR TO
5										16	YES 2	NO		CDMPLETION DF CAUSE OF DEATH?
E														1 YES 2 NO
₹	25. WAS CASE REFERRED TO	O MEDICAL					28 DI	ACE OF O	EATH (Cho	ock only one)		_		
PHTSICIAN	EXAMINER?		HOSPITAL:			OTHER	₹:							
-	27. MANNER OF OEATH		1 Inpatient 2			-			sidence	8 Other (Sc				
	40	0 41	28a. DATE OF (Month, Di		28b. TIM	E OF URY	28c. INJ WC	URY AT		28d. OEŞCRI	BE HOW IF	NURY OCC	CUREO	
		Pending Investigation				M	1 🔲	rES 2] NO					
	3 Culoido	Could not be	28e. PLACE O	FINJURY -	At home, term,	street, fact	ory, offic			28t. LOCATIO	N (Street a	nd Number	or Rural F	Route Number,
1		determined	Dorraing,	atc. (Specify)						City or To	wn, State)			
4	29a. CERTIFIER	//G C 11					-		_					
	(Check only		CIAN: To the best of											
COMPLEIED	2 MEO	CAL EXAMINE	R: On the beals of a	amination and	d/or investigation	n, In my o	pinion, d	eath occur	ed at the t	time, data and	place, and	d due to th	e cause(a	and menner as stated.
	296. SIGNATURE AND TITLE	OF CERTIFIER	11 2 .					29c LICE	NSE NUM	BER		204 DATE	SIGNED	(Month, Day, Year)
ŭ		46-	1/200	12.11				1)-	100	7/12	- 1			
2	- POV	90 V	FULL	17.				3/	00	7/2		F	eb.	24, 1993
	30. NAME AND ADDRESS OF	P Kon	o completed caus	E OF DEATH	(ITEM 27) (Type,	Print)	הם	D .		302	000	200		
W			111.00	20	618 Ri	uge	nd.	Dam	ascu	s, Md.	208	572		
	31. DATE FILED (Month, Day, FEB 2	Year)	32. REGISTRA											
		F 113()") // .		Randage									
1	LERY	0 1333	915.	i h	70									

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE MOSFIDAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FLINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be med within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If I ham 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

Dr. Thomas Johnson,

31. DATE FILED (Month, Day, Year)
MAR - 3

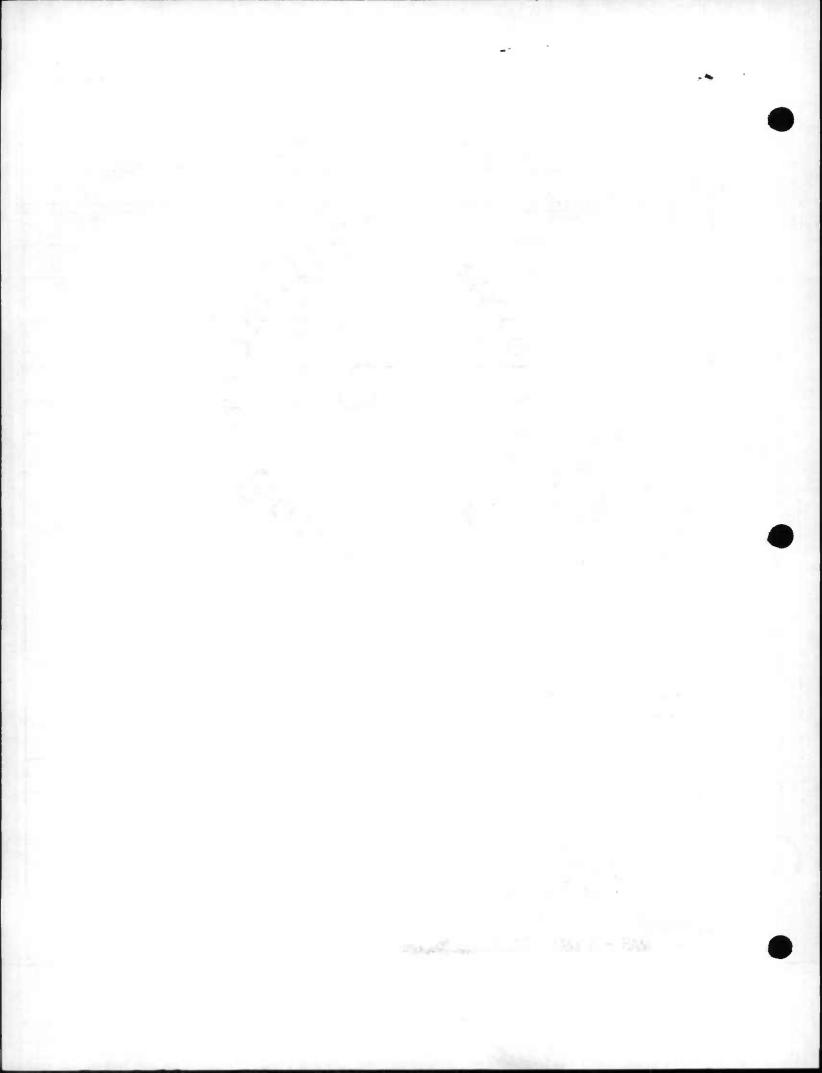
MD

32. REGISTRAR'S SIGNATURE Julia Savidon 18

REGISTRAR				ICATE				MENIA	REG. NO	-		
1. DECEDENT'S NAME (First, Middle, Lest)								2. DATE	OF DEATH	AY	YEAR	3. TIME OF DEATH
Edna Marie	EDGAR								ch 2,		YEAH	10:00 A
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. less	birthday)	IF UNDER		IF UNDER		7. DATE	OF BIRTH		8. BIRTHE	LACE (State or Foreign
214-74-3844	1 🗌 M 2 🙀 F	87	YRS.	MONTHS	DAYS	HOURS	MIN.		15,	1904	Mary	land
9a. FACILITY NAME (If not institution, give stre	eet and number)			9b. CITY,	TOWN (R LOCATI	ON OF DE				TY OF DE	
Garrett County Me	morial H	ospital			0a	kland	d			Gar	rett	
RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY												
MD Garre	tt		10c. CIT	Y, TOWN O	R LOCAT		Dak1	and				10d, INSIDE CITY LIMITS? 1 X YES 2 NO
10. STREET AND NUMBER					101	ZIP CODI	E			10g. CITIZ	EN OF W	HAT COUNTRY?
309 South Second	Street							2155	50			USA
1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2 N			f yes, sp	ENDENT Cocify Cube	n, Mexica	in, Puerto I	i? (Specify Ye Rican, etc.)	e or No—	14. RACE Black, Specify	- American Indian, White, etc.
15. DECEDENT'S EDUCA	ATION	16a. DE	CEDENT'S	USUAL O	CCUPATIO	ON .		16b	. KIND OF BU	SINESS/IND	USTRY	
15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12) 7 17. FATHER'S NAME (First, Middle, Last)	College (1-4 or 5 +		Do NOT u	vork done de retired.)		st of workin	9		Hom	0		
17. FATHER'S NAME (First, Middle, Lest)						16. MOTI	HER'S NA	ME (First 1	Middle, Malden			
	ohn		Fr	antz			Rosie				Cas	too1
19a. INFORMANT'S NAME (Type/Print)		198							ber, City or Tow			reer
Mabel V. Rowe									ıd, Ma			1550
20a. METHOD OF DISPOSITION		20b. PLACE A					, 00			CATION -		
1X Buriel 2 Cremation 3 Remov	val from State	cometery, creating that the	natory or o	ther place)	eme t	0.737		3/5				ryland
21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE					D ADDRES	SS OF FA) J Va	KIAIIU	, Mai	Lyland
Bradley A. It	boult				Stev 32 S	art S. Se	Fune	eral 1 St.	Home , Oak	land,	MD	21550
23. PART I. Enter the diseases, or co	emplications that	caused the da	nth. Do r									Approximata
shock, or heart failure. LI IMMEDIATE CAUSE (Final	ist only one caus	se on aach line.										Onset and Deat
disease or condition	Pneumo	nia										24 Hours
resulting in death) a.		OR AS A CONSEC	UENCE O	F):								24 110013
												İ
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO	OR AS A CONSEC	UENCE O	ົງ:								
cause. Enter UNDERLYING												
CAUSE (Disease or Injury that Initiated events	DUE TO	OR AS A CONSEC	UENCE O	ን:								
resulting in death) LAST												
DATE II COL - I - III - III												
PART II. Other significant conditions ASHD with Valvula			suiting	n the un	derlying	g cause g	given in	Part I.	24a. WAS AN PERFO			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
								_	1 TYES	2 ⊠ NO		COMPLETION OF CAUSE OF DEATH?
Cerebrovascular i	nsuffici	ency						_				1 _ YES 2 _ NO
Diabetes Mellitus												
25. WAS CASE REFERRED TO MEDICAL	HOSPITAL:					ACE OF D	EATH (Ch	eck only on	e)			
II EXAMINER?	1 Inputiont 2 🛛	ER/Outpatient 3	□ DOA	OTHER		• 5 □ Re	eidence	8 🗆 Othe	r (Specify)			
EXAMINER? 1 YES 2 NO			28b. TIM	E OF URY	28c. INJ	URY AT		28d. DES	CRIBE HOW	INJURY OCC	URED	
EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	28e. DATE OF (Month, De	N. 1960/7		M		ES 2	NO				b.	
1 TES 2 NO 27. MANNER OF DEATH 1 No Natural 5 Pending	28e. DATE OF (Month, De	y, rear)										
2 Accident survival accident a Could not be determined	(Month, De	FINJURY — At horate. (Specify)	ne, ferm,	street, facto	ory, offic	,			ATION (Street or Town, Stete)		or Rural Ro	oute Number,
2 Accident survival accident a Could not be determined	28e. PLACE Of building,	FINJURY — At horate. (Specify)						City	or Town, Stete;)		oute Number,
2 Accident survival accident a Could not be determined	28e, PLACE Of building,	F INJURY — At horate. (Specify)	ith occum	ed at the ti	me, data	end place,		to the cau	or Town, Stete	nner es state	od.	
2 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	28e, PLACE Of building,	F INJURY — At horate. (Specify)	ith occum	ed at the ti	me, data	end place,		to the cau	or Town, Stete	nner es state	od.	
2 Accident Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only 1 KZ CERTIFVING PHYSICI	28e, PLACE Of building,	F INJURY — At horate. (Specify)	ith occum	ed at the ti	me, data	end place,		to the cau	or Town, Stete	nner es state	od. o ceuse(e)	

311 N. Fourth St., Oakland, Maryland

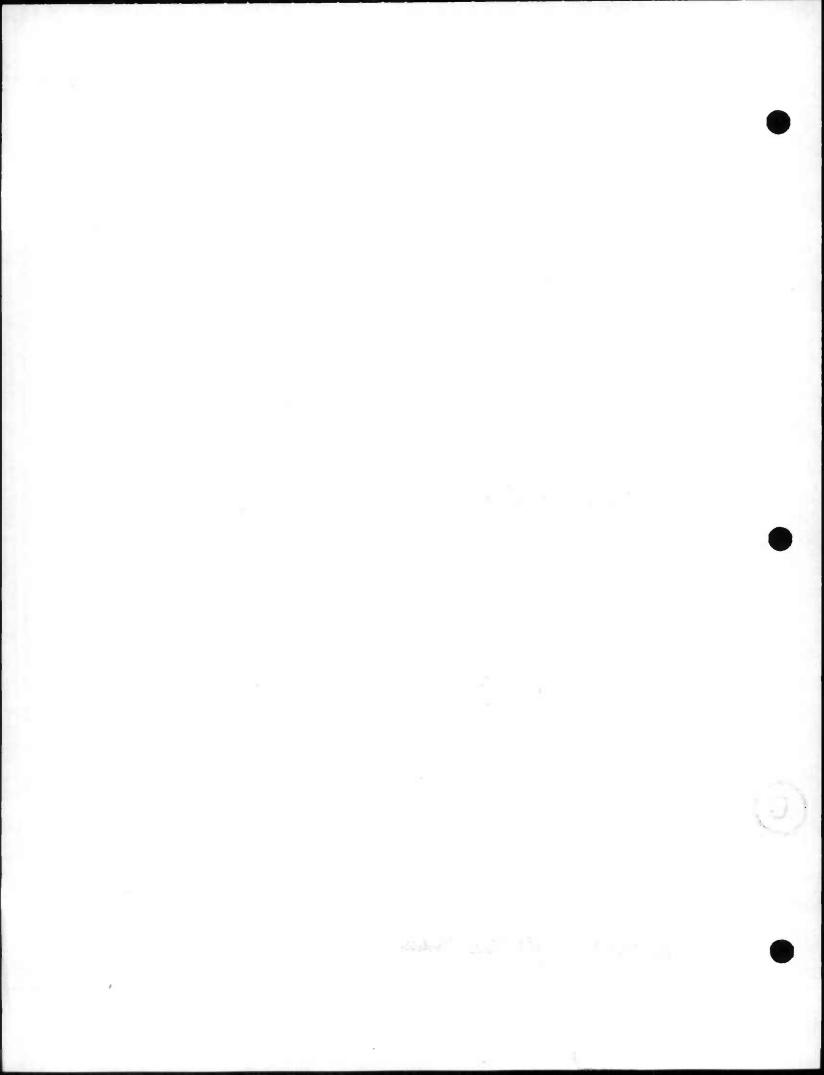
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BALTIMORE, MARYLAND 21215-0020

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6	and	
TO THE FUNERAL DIFFERENCE THE CONTRIBUTION CONTINUES TO THE SIGNED BY THE Attending physician and comp	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, or	
Eag.	ō	
has b	Dept.	-
icate	State	
certi	the	
器	with	
Ė	death	
ě	after	
BHIG	hours	
A	2	
FUNER	within	
THE.	filed	-
2	8	1

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTA CERTIFIC	ENT OF I	HEALTH AND	MENTAL HYGIEI	NE) (J 0 1	50
	1. DECEDENT'S NAME (First, Middle, Lest ROS]			IOTT		2. DATE OF DEATH MONTH		YEAR	TIME OF DE	EATH A
	4. SOCIAL SECURITY NUMBER 398-30-7989	5. SEX 6. AGE (1)		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		. BIRTHPLA	CE (State or	
QC.	9a. FACILITY NAME (If not institution, give	street and number) General Ho			OR LOCATION OF D		9c, COUNT	Y OF DEAT	н	
CTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN				ridge		Doro	hes	ter	
DIRE	MD. Do	rchester	10c. City, to	Ca	mbridge	2			I. INSIDE CI LIMITS? YES 2	
ERAL	10e. STREET AND NUMBER 520 Glenk	ourn Ave.		10	21613			S.A.	COUNTRY	?
BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married 3 Never Married 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	XXNO	If yes, sp	ENDENT OF HISPA	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)		4. RACE — Black, W	American In hila, atc. Whit	The state of
TED	15. DECEDENT'S ED (Specify only highest grad	UCATION le completed)	16a. DECEDENT'S USL	done during mo	ON st of working	16b. KIND OF BU	JSINESS/INDUS	STRY		
once. COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+) 5	teacl			pub	lic s	choo	1s	
d at one	17. FATHER'S NAME (First, Middle, Løst) Hans	Peter Nels	son		18. MOTHER'S NA Mar	tena Th	o Sumame) eodori	a N	ie1s	en
TO B	190. INFORMANT'S NAME (Type/Print) Mrs. Eileen Sc	chuchardt	19b. MAJLING ADI 402 S	Sandy	nd Number or Rural Hill R	Route Number, City or To. d. Cambri	vn, State, Zip Ci	d. 2	1613	
must b	20a. METHOD OF DISPOSITION 1 Description D	noval from Stata Ceme	PLACE AND DATE OF DI etery, crematory or other DOGIAWN	sposition (Na Dace) Cemete	ery	- 1.	onto			
examine	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE	9		ADDRESS OF FA	Thoma St. Camb	s Fun			
c event, the medic	23. PART I. Enter the dieeesea, or ahock, or heert feliure. IMMEDIATE CAUSE (Finel disease or condition reaulting in death)	a.	och line.	neur		h ae cerdlec or reap	iratory arree	t,		mate Between nd Death
Injury, or other traumatic event, the medical examiner must be notified at once. AL CERTIFICATION TO BE COM	Sequentielly list conditions, it any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Diseese or Injury that initieted events resulting in death) LAST	c	CONSEQUENCE OF):							
shows any MEDIC.	PART II. Other significent condition	ne contributing to deeth but any Deg.	ot not resulting in the	e Underlying	scenee given in	Pert I. 24a. WAS AP PERFOI 1 YES	RMED?	AVA CON OF	RE AUTOPSY ILABLE PRIO IPLETION OF DEATH?	F CAUSE
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ОТ	26. PL HER;	ACE OF DEATH (Ch	eck only one)				
is marked, or item 23 D BY PHYSICIAN	1 _ YES 2 _ NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outpa	28b. TIME OF	28c. INJ	JRY AT	s Other (Specify) 28d. DESCRIBE HOW	NJURY OCCUP	RED		
BY mark	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY		ES 2 NO					
m 28 is ETED	3 Suicida S Could not be 4 Homicide detarmined	28a. PLACE OF INJURY - building, etc. (Specif	— At home, farm, street	, Inctory, office		281. LOCATION (Street City or Town, State	and Number or	Rurel Route	Number,	
IMPORTANT: If Item 28 O BE COMPLETE		ICIAN: To the best of my knowle ER: On the basis of examination						ause(e) and	l manner aa	atated.
PORTA BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE NUN		29d. DATE S			,
₹ P	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEAL			214.	349	•	3-1.	2-9-	3
	The state of the s	STATE CAUSE OF DEA	in (ii Em 21) (type, Print	,						
	31. DATE FILED (Month, Day, Year) MAR 18 '93	Ja. REGISTBAR'S SIGNAT	pandell'							



3. TIME OF DEATH

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MPORTANT

2, 3 should

2. DATE OF DEATH YEAR Alden. Ellis John 1993 2:32 P.M March 16 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign DAYS HOURS 002-03-5046 1 XM 2 F 81 Oct. 26, 1911 Maine 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Memorial Hospital at Easton Easton Talbot RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Caroline Denton 1 TYES 2 THO FUNERAL 10e, STREET AND NUMBER 101, ZIP CODE 10g CITIZEN OF WHAT COUNTRYS 9420 Fisher Road 21629 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Ri
1 ☐ YES 2 ☒ NO Specify: 1 Never Married 2 X Married IF YES, GIVE WAR OR DATES BY Specify: 3 Widowed 4 Divorced Caucasian COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY TON nost of working Elementary/Secondary (0-12) College (1-4 or 5+) 12 HS grad. Food Processing 1 yr. Inspector 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Maria Hoffses Irvin Hobart Ellis BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Elsie L. 9420 Fisher Road, Denton, Maryland **Ellis** 20a. METHOD OF DISPOSITION
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 1 Burial 2 Cremation 3 L 4 Donation 5 Other (Specify) Spring Hill Cemetery 3/20 Easton, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Moore Funeral Home, P.A. -Drawer B, Denton, Maryland 21629 23. PART I. Enter the diseases or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition Myocordial resulting in death) DUE TO (OR AS A CONSEQUENCE OF) MEDICAL CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 | NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 TES 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 💢 DOA ne 5 🗆 Rasidence 6 🗀 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner on stated. 2 MEDICAL EXAMINER: On the besia of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 118/93 76 D33 m 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 660 COKWIN BOX 31. DATE FILED (MO) 32. REGISTRAR'S SIGNATURE a Davidson-Randale

3. TIME OF DEATH

BIRTHPLACE (State or Foreign Country)

10d, INSIDE CITY LIMITS? 1 TES 2 NO

White

14. RACE — American Indian, Black, White, etc.

Pennsylvania

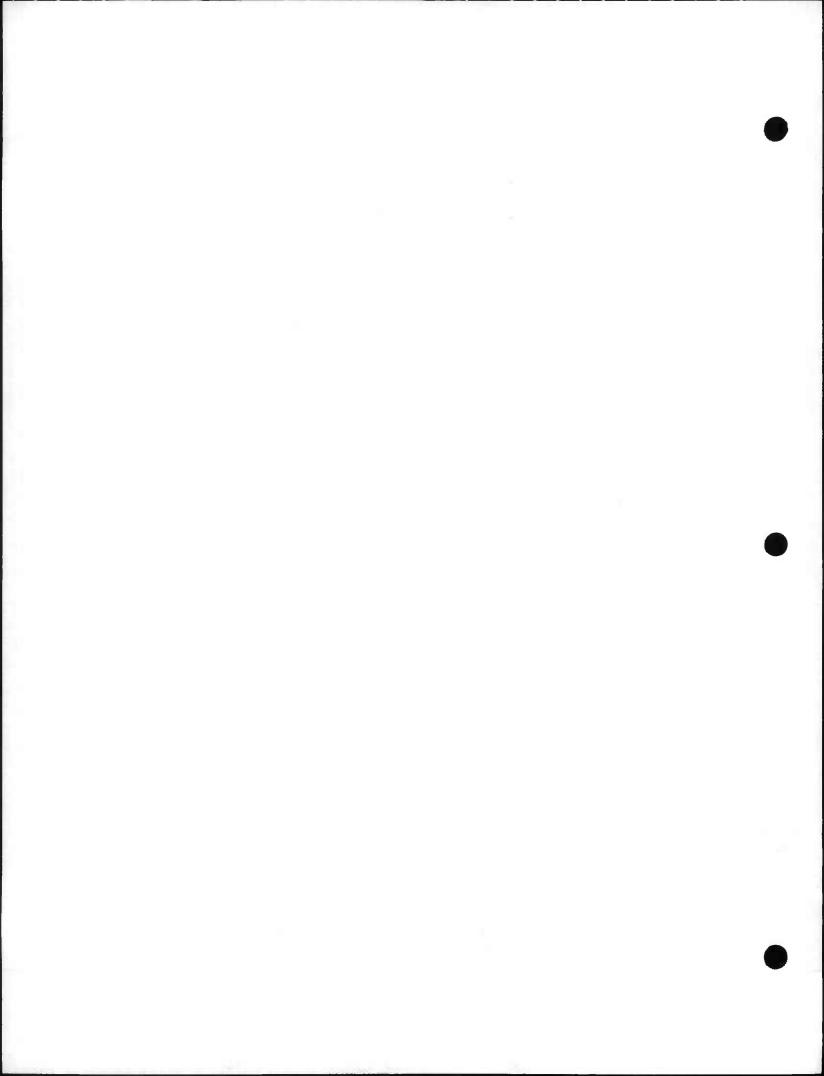
10g. CITIZEN OF WHAT COUNTRY? United States

1:00 P.M

REG. NO.

		1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE	OF DEATH		WESE	3. TIME OF E			
		Harry H. Fo	outs								Marci	h 12,	1993	YEAR	1:0			
		4. SOCIAL SECURITY NUMB	ER	5. SEX	8. AGE (In	yrs. last birthda			IF UNDER	24 HRS.	7. DATE (OF BIRTH		6. BIRTI	IPLACE (State			
		167-07-0299)	1 X M 2 □ F	7	8 YRS	MONTHS	DAYS	HOURS	MIN.		. 15,19	14	Penn	_ຫ .sy1van			
should		9a. FACILITY NAME (If not in:	stitution, give s	street and number)			9b. CITY	, TOWN	OR LOCATION			,		NTY OF E				
020 physician. burial-transit permit. Pages 1, 2, 3 should	DIRECTOR	Rockville I		g Home					Rockv	ille			Мо	ntgo	mery			
Des 1	<u> </u>	10e. STATE	10b. COUNT	Υ		10c.	TTY, TOWN (OR LOCA	ATION						10d. INSIDE			
2	盲	Maryland		Montgome	ry			1	Rockv	ille					1 YES 2			
m _e	¥	10e. STREET AND NUMBER						10	of. ZIP CODE	E			10g. CIT	IZEN OF	WHAT COUNTR			
n. ansit	FUNERAL	15120 Westh	ury R	.oad						2085	53		Uni	ted	States			
20 Sicial rial-tr	5	11, MARITAL STATUS		12. WAS DECEDEN			13.	WAS DE	CENDENT C	F HISPANI	C ORIGIN	? (Specify Yes	or No-	14. RAC	E — American k, White, etc.			
fing ph	ВУ	1 Never Married 2 2 3 Divo	if YES, GIVE WAR OR DATES 1 YES 2 X NO Specify:										Specify: Wh					
8 g 21		15 DEC	FDENT'S FOU	WWII DENT'S EDUCATION 188. DECEDENT'S USUAL OCCUPATION 186. KIND														
or aff	COMPLETED		highest grade	completed)		(Give kind	of work done	during m	nost of working	g	100.	KIND OF BUS	IND OF BUSINESS/INDUSTRY					
D 2 Spital o	립	12	12)	College (1-4 or 5+) Business Development A.									A.R.I.					
YLAND by the hospit be detached at once.	ŏ	17. FATHER'S NAME (First, MI	ddle, Last)															
A to the	BE C	Harry C. Fo	uts						Mar	y M.	(n	ot ava	ilab	le)				
MARYLAND retained by the hospita 5 should be detached notified at once.		194. INFORMANT'S NAME (7)	pe/Print)			19b. MAILI	NG ADDRESS	S (Street	and Number	or Rural Ro	oute Numb	er, City or Town	n, State, Zij	Code)				
	2	James E. Cr	ickey	, Jr.		1512) West	tbuı	ry Ro	ad Ro	ckvi	ille,	Mary	land	20853			
BALTIMORE, sa after death. Page 6 may be not the funeral director, page removal.		20e. METHOD OF DISPOSITI		ovel from State	20b. I	PLACE AND DA	E OF DISPOS	ITION (A	leme of	<u> </u>	OATE	20c. LO	CATION -	City or To	own, State			
MORI ge 6 may irector, p		4 Donation 5 Other	(Specify)	OVER HOLL STATE	- Ga	te of	Heave	n Ce	emete	ry_3/	17/9	3Silv	er S	prin	g, Mar			
SALTIMORE death. Page 6 may e hineral director, page.	- 8	21. SIGNATURE OF FUNERAL	SERVICE LI	CENSEE			22.	NAME A	ADD ADDRES	SS OF FAC	iLITY RO	bert	A. P	umph	rey Fu			
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B. hours after d in by the or removal		23. PART I. Enter the di	seases, or	complications the	it Fouded	the death. D	not enter	the m	ode of dy	ng, such	as card	lac or reapi	ratory ar	reat,	Approx			
DO DO E		immediate cause (Fin		List only one cau	ise on ea	ch line.									Onset			
- 28 =		disease or condition resulting in death)	→	Recurre	ent P	neumon	ia											
3760, feed within completely ial, cremati;		rosulting in country		DUE TO	(OR AS A	CONSEQUENCE	OF):											
cxecuted within and complete o burial, creminatic event,	Z	Sequentially list conditi		Recurre											ļ			
X cz E	CATION	if any, leading to immed	liate		-	CONSEQUENCE	,											
BO icate be physicial to prior the prior or trau	2	cause. Enter UNDERLY! CAUSE (Disease or Injur		e. Recurre		ecubit									_			
P.O. E	Ē	that initiated events resulting in death) LAST		Alzheir		COMSEQUENCE	OF):								İ			
	CERTIFI		-	d											-			
D at the D	A.	PART II. Other aignificat	nt condition	e contributing to	death bu	t not recuitin	g in the un	derlyir	ng ceuse g	iven in F	art i.	24a. WAS AN PERFOR		24b	. WERE AUTOPS			
ECOR uires that signed by Health an	MEDICAL				_						_	1 TYES 2			COMPLETION OF DEATH?			
REC requires een sign of Healt	M										_		21		1 TYES 2			
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上午 章章	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:			OTHER		LACE OF D	EATH (Chec	k only one)						
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PHYSICIAN: this certifical with the Sta	۵. ا	27. MANNER OF DEATH 1 ☑ Natural 5 ☐ I	Pending	26e. DATE OF (Month, D		28b. 1	IME OF NJURY	W	JURY AT ORK?		28d. DE\$	CRIBE HOW II	NJURY OC	CUREO				
ON OI PHYS After this death with	B	2 Accident	nvestigation	20 DI ACE O	AF IM HIPPY	44.5	M		YES 2									
after d	8		Could not be letermined	building,	etc. (Specif	- At home, farr	, street, fact	ory, offi	Ce		261. LOCA City o	TION (Street or Town, State)	and Numbe	or Aural I	loute Number,			
thours a	COMPLETE	29a. CERTIFIER	7 - Series (S.)	5 7-0 month	-	781 5-651	-13***	_					_					
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TO THE HOSPI TO THE FUNER De filed within 7	8			R: On the basie of e	Ammination	end/or investiga	tion, in my o	pinion,	death occur	ed at the t	lme, date	and place, sn	d due to ti	te cause(s) and manner			
MAN HE HE DO	BE	296. SIGNATURE AND TITLE	OF CERTIFIE	1,11/	0	MI			29c. LICE	NSE NUME	BER				(Month, Day, Y			
₽₽₽	2	manue		Will.	ne	11							M	arch	12, 1			
· \		30. NAME AND ADDRESS OF Frauke West						d Ro	ckvi	11e.	Mars	land	2085	1				
,		31. DATE FILEO (Month, Day, 1		32. REGISTRA	-		2.041			,								
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Dc. LOCATION — City or Town, State ilver Spring, Maryland rt A. Pumphrey Funeral 300 West Montgomery aryland 20850-2805 respiratory arrest, Approximate Onset and Death 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? WAS AN AUTOPSY PERFORMED? YES 2 NO 1 TES 2 NO HOW INJURY OCCURED (Street end Number or Rural Route Number, State) nd manner ee stated. ace, and due to the cause(s) and manner es stated. 29d. DATE SIGNEO (Month, Day, Year) March 12, 1993 nd 20851 DHMH-16 Rev 1/89



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31. DATE FILED (Month, Day, Year)

MAR

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

Junia Davidson Randalle

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THE INDITION OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or arter	me Thread. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1	irs after (PORTANT: Il Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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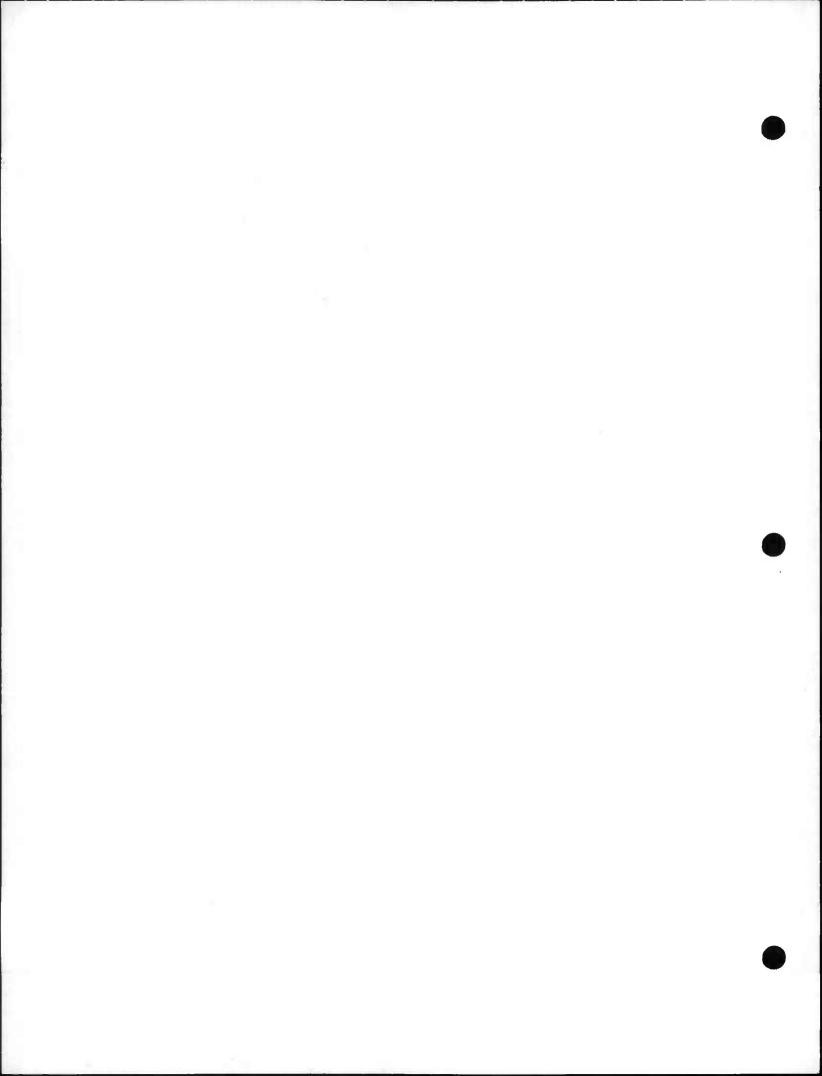
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH YEAR Mary Bernadette Flint 1993 March 10, 1:00 AM 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 X F 79 577 10 5498 Oct. 12,1913 Washington, D.C 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Rockville Nursing Home Rockville Montgomery RESIDENCE OF DECEDEN 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Rockville 1 X YES 2 NO FUNERAL 10s. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 627 Crocus Drive 20850 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black. White, etc. 1 Never Married 2 Married 1 ☐ YES 2 NO Specify ВҰ 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade International Brotherhood Elementary/Secondary (0-12) College (1-4 or 5+) of 2 Secretary Electrical Workers 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) John B. Horstkamp Katherine В. Rodler BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Kathleen F. Boswell 1212 Clagett Drive, Rockville, Maryland 20851 20a. METHOD OF DISPOSITION
1 № Burlai 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 4 Donation 5 Other (Specify) Olivet Cemetery 3-15 -93 Washington, D.C. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery M00689 Avenue, Rockville, Maryland 20850-2805 Mant 23. Pany / Enter/the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart feliure. List only one cause on each line. Approximate interval Between **IMMEDIATE CAUSE (Finei** Onset and Death disease or condition_ Congestive Heart Failure 4 days resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Renal Failure CERTIFICATION 4 months Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING Diabetes Mellitus 5 years CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? Chronic Obstructive Pulmonary Disease 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO e 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 🔀 Natural 5 Pending Investiga 1 YES 2 NO BY 2 Accident
3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29s. CERTIFIER

(Chack only 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 __ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) . Comwell MD

Stephen C. Cromwell, M.D. 615 West Montgomery Avenue, Rockville, Md. 20850

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March 10, 1993



FOR STATE REGISTRAR

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WISION OF VITAL RECORDS, P.O. BOX	H. ALT NOING PHYSICIAN: The law requires that the death certificate he exe
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	4 DEGEDENTIA MANAGES												
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	4. SOCIAL SECURITY NUM		5. SEX	B. AGE (In yrs.		MONTHS I		UNDER 24 HRS.	7. DATE OF (Month, E	BIRTH Pay, Year)		. BIRTHPLACE Country)	(State or Foreign
	105-05-539		100	98	8 YRS.				01-17	-1895		Italy	1 1 7 7
œ	9a. FACILITY NAME (II not i							CATION OF DE	ATH		9c. COUNT	Y OF DEATH	
DIRECTOR	Meridian N	ursing	<u>Home</u>			Sil	ver S	Spring			Mo	ntgome	ery
3	10a. STATE	10b. COUNT			10c. CiT	, TOWN OR	LOCATION					10d. I	NSIDE CITY
	Maryland	Mo	ntgomery		Si1	ver S	pring	5				-	JMITS? YES 2 NO
AL	10a, STREET AND NUMBER						10f. ZIP	CODE			10g. CITIZE	N OF WHAT C	
ER	3227 Bel Pr	e Road	1					20906		- 1	11	SA	
FUN	11. MARITAL STATUS 1 Never Married 2	l second or	12. WAS DECEDENT FORCES? 1	EVER IN U.S.	ARMED	13. WA	S DECENDE	ENT OF HISPAN Cuban, Maxica	IIC ORIGIN? (Specify Yes			nerican Indian,
ВУ	3 X Widowed 4 Div		IF YES, GIVE WA		4110	1 [YES 2	NO Specify	n, Puarto Hici	in, etc.)		Specify:	
	15. DEG	CEDENT'S EDU	CATION	160	DECEDENT'S	IISHAL OCC	IDITION		I an un				Thite
ETED	(Specify on Elementary/Secondary (ly highest grade	College (1-4 or 5+)		(Give kind of w life, Do NOT us	ork done dur	ing most of v	working	166. Kr	ND OF BUSI	INESS/INDUS	STRY	
4	Listing y occordally (-12)	2	Er	nginee	r			F1	ectro	nico		
COMI	17. FATHER'S NAME (First, A	fiddle, Last)			.6200	_	18.	MOTHER'S NA					
ш	Cosmo Fras	cati						ancy I			,		
TO B	194. INFORMANT'S NAME (Type/Print)			196. MAILING	ADDRESS (S		imber or Rural F			State, Zip Co	ode)	
F	Nancy Shan	non						Drive					0905
	20a, METHOD OF DISPOSIT		oval from State	20b. PLAC	EANDDATEO	FDISPOSITIO	ON /Name of		DATE	200 100	ATION - CIT	y or Town, Sta	rte
	4 Donation 5 Donate	(Specify)		St.	Mary s	er place) S Ceme	etery	03-	16-93	Del	Witt,	New Y	ork
	21. SIGNATURE OF FUNERA					22. NA	ME AND AD	naldi	CILITY				20904
	> Can	nis A	Capiton	>								C.	ing, MD.
	23. PART I. Entar the d	isaasea, or o	complications that of	caused tha	death. Do n	ot entar th	e moda of	dving, auch	as cardiac	or manin	STIV	er Spr	Approximate
	shock, or h IMMEDIATE CAUSE (Fit	dert failure.	Liet only one cause	on each li	ne.						,	1	ntervel Between
	disease or condition resulting in death)	→	Artos	1251	lorat	inh	0011	+ M	1000	. 0		- 1	Onset and Death
	resulting in destri)		DUE TO (O	R AS A CONS	EQUENCE OF):	اماسات	Cu	LEA	11			
Z			DUE TO (O	mil	e D	eur	enti	a.				ĺ	
E	Sequentially list condit if any, leading to imme	diate	DUE TO (O	R AS A CONS	EOUENCE OF):						-	
2	CAUSE (Disease or inju	ing	c										
	that initisted events resulting in death) LAS	Т	DUE TO (O	R AS A CONS	EOUENCE OF	12							
CERTIFICATION			d										
- 11	PART II. Other aignifica	int condition	a contributing to de	eth but not	reaulting Ir	the unde	riying cau	sa given in i	Part i. 24	. WAS AN A		24b. WERE	AUTOPSY FINDINGS
EDICAL									_ ,	PERFORM		COMPL	BLE PRIOR TO ETION OF CAUSE
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SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL					28. PLACE C	OF DEATH (Che	ck only one)				
Š	1 TYES 2 NO		HOSPITAL:	R/Outpatient	3 🗆 DOA	OTHER:	Homa 5	Rasidence	B Other (S)	pecify)			
PHY	27. MANNER OF DEATH		28a. DATE OF IN (Month, Day,		28b. TIME		c. INJURY A	ır	28d. DESCRI	BE HOW IN.	JURY OCCUP	RED	
à l		Pending Investigation					YES	2 🗌 NO					
		Could not be	28s. PLACE OF I building, etc	NJURY — At I	homa, farm, at	reet, factory,	offica		281. LOCATIO	N (Street and	d Number or	Rural Route Nu	imber,
		determined								, out,			
COMPL	29a. CERTIFIER (Check only one) 2 MEDI	TFYING PHYSICAL EXAMINE	CIAN: To the best of m	knowledge, onlination and/o	death occurred	at the time,	data and p	lace, and due t	to the cause(s) and mann	er as stated.	ause(a) and m	anner sa steted
ŭ W	296. SIGNATURE AND TITLE						_	LICENSE NUM					
60 II	Lanie	sa de.	Sarin	u	CABS		1	7)13	548	0	DATES	IGNED (Month,	Day. Year)
		P. P.											
	30. NAME AND ADDRESS OF		COMPLETED CAUSE	OF DEATH (IT	EM 27) (Type, I	Print)	-	1	- 10	,		10.1	
0	30. NAME AND ADDRESS OF		COMPLETED CAUSE A & SAT 32. REGISTRARY	2110	7801	9501	EB11	A Az	ENU	E SI	LUER	SPRI	va mo

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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Pages 1, 2, 3 should

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filled in by the funeral director, page 5 should be detached on, or removal.

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and completely fille burial, cremation,

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31. DATE FILED (Month, Def. Year)

ATTENDING

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TAIL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hor
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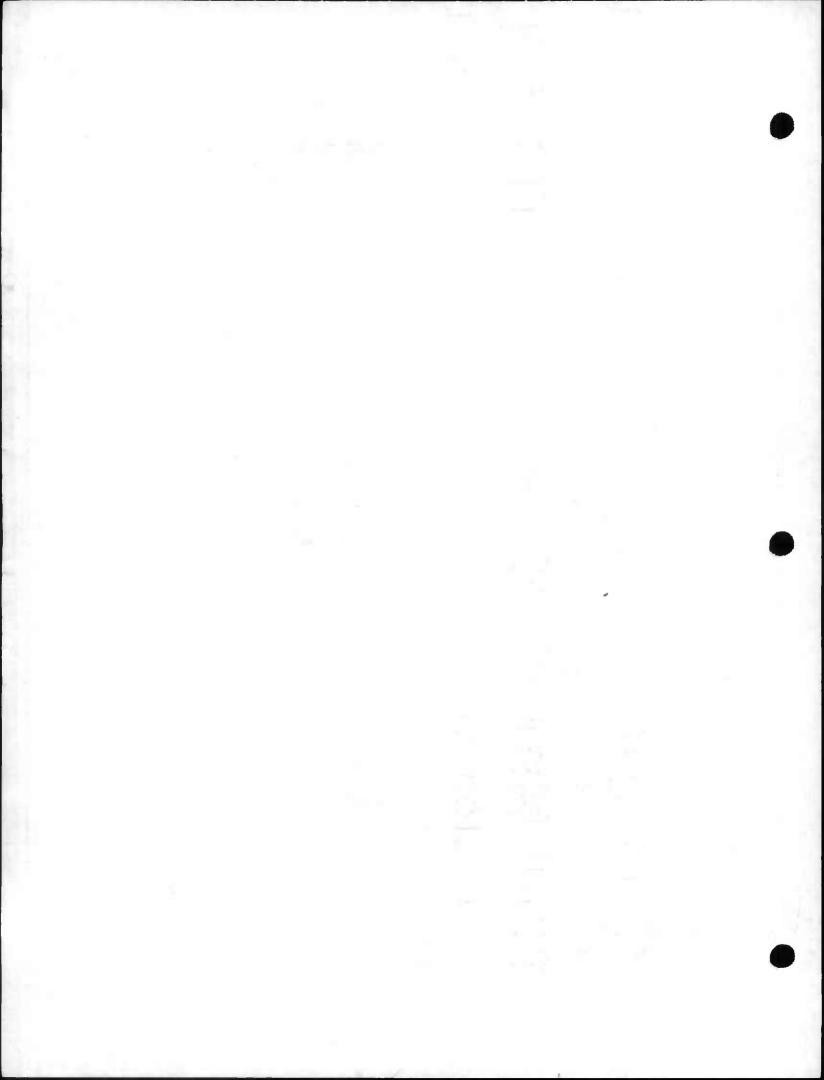
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 2. DATE OF DEATH MONTH 14, DAY 1993 YEAR 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 8:42A " ETTA NEWTON FAULKNER 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Yea IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) MONTHS DAYS HOURS 1 M 2 XF 70 217-32-3211 11-06-1922 Virginia 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Greenbelt Greenbelt Nursing Center PRINCE GEORGES DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Howard 1 YES 2 NO Savage FUNERAL 10e. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 101. ZIP CODE 8954 River Island Drive, #104 20763 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 XNO 1 Never Married 2 Married 1 YES 2 NO Specify: Black Specify: BY **\$**₩idowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT uss retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 7th Cook 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) James Newton, Sr. Ħ Bertha Reed BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Margaret Faulkner (Daughter) 9930 Naylor Ave., Laurel, MD 20723 pe 20e. METHOD OF DISPOSITION
1 💢 Burlel 2 🗆 Cremation 3 🗆 Removal from State
4 🗆 Donation 5 🗆 Other (Specify) DATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name must Maryland Veterans Cem. 3/22 Cheltenham, Md 22. NAME AND ADDRESS OF FACILITY
SNOWDEN FUNERAL HOME, P.A.
20850 21. SIGNATURE OF FUNERAL SERVICE LICENSE examiner medicai 23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, **Approximate** shock, or heert fellure. List only one ceuse on each line. interval Between colorectal IMMEDIATE CAUSE (Finel **Onset and Death** Cancer the disease or condition_ year cauced reaulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING has been signed by the attending physician Dept. of Health and Mental Hygiene prior to other CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 6 23 shows any injury, PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 T NO OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h Hem HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Rasidenca 8 □ Other (Specify) 1 YES 2 NO etlent 2 - ER/Outpatient 3 - DOA marked, or 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED INJURY 1 Natural 5 Pending M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 69 FUNERAL DIRECTOR: within 72 hours after 4 Homicide 28 ᆸ Hem 29a. CERTIFIER
(Check only one)

MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 겁 TO THE HOSPITAL (TO THE FUNERAL EDGE AND TO THE FUNERAL EDGE WITHIN 72 has IMPORTANT: If IR COM 2 MEDICAL EXAMINER: On the basis of examin stion and/or investigation, in my opinion, death occured at the time, data and piece, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND THEE OF CERTIF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, De 2 2 30, NAME AND ADD

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32. RIGISTRANIO SIGNATURE PROJECT

20707



BALTIMORE, MARYLAND 21215-0020

THE HOSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2+ hours after death. Page 6 may be retained by the hospital or attending physician.

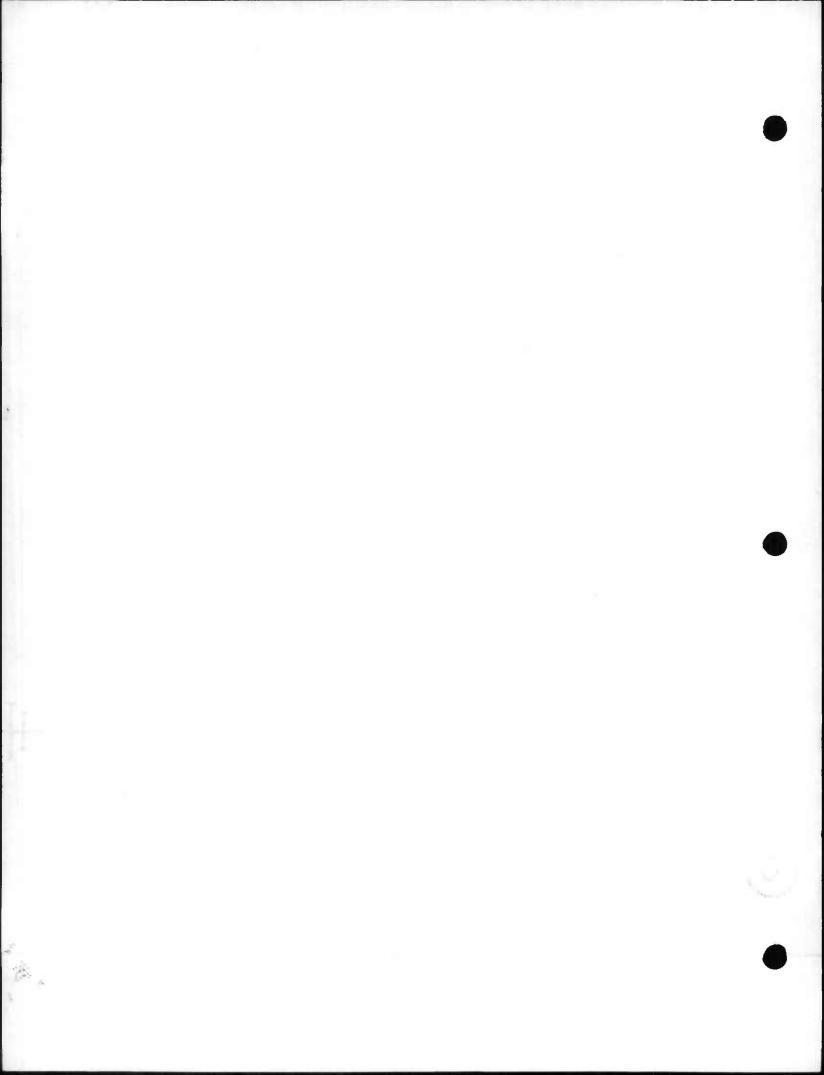
OF HIGH WITHING STATE THIS certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

Dotminio Euro Elum	3. TIME OF DEATH
Patricia Eve Flynn March 15, 1993	9:05 A M
MONTH DAVID LIGHT (Month Day Year)	. BIRTHPLACE (State or Foreign Country)
233-88-7970 1 M 2 XF 39 Yes.	New Jersey
	Y OF OEATH
5 2709 Valley Way Cheverly Prin	ce George's
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION	10d. INSIDE CITY
2709 Valley Way Cheverly Prin RESIDENCE OF DECEDENT 100. STATE 100. COUNTY Maryland Prince George's Cheverly	LIMITS?
011010121	1 X YES 2 NO
E 0700 W 33	
11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 14)	ed States
The state of the s	4. RACE — American Indian, Black, White, etc. Specify:
m 3 widowed 4 Divorced	White
15. DECEDENT'S EQUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	STRY
Elementary/Secondary (9-12) College (1-4 or 5+)	
6 Administrative Specialist Toyota Motor	Sales, Inc.
Paul Harvey Flynn Paul Harvey F	
0	ode)
Gregory Anderson Same as 10 20a. METHOD OF DISPOSITION DATE 20c. LOCATION — CR	TO 10 1 10 10 10 10 10 10 10 10 10 10 10 1
1 Burdel & Commellan & Barney for State	
4 Donation 5 Other (Specify) Suburban Crematory 3-16 Silver Sp. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY	ring, Maryland
Rapp Funeral Services, P. A.	
955 GISC AVENUE, SILVER SPT.	ng, MD 20910
23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock, or heart failure. List only one cause on each line.	Approximate interval Between
IMMEDIATE CAUSE (Final disease or condition	Onset and Death
resulting in death) a. Due To (OR AS A CONSEQUENCE OF):	Thears
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):	
Cause. Enter UNDERLYING CAUSE (Disease or Injury	
that initiated events DUE TO (OR AS A CONSEQUENCE OF):	
d	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
Z4s. Was AN AUTOPSY PERFORMED? 1 VES 2 M NO	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PERFORMED? 1 YES 2 X NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE
PERFORMED? 1 YES 2 X NO	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PERFORMED? 1 YES 2 X NO	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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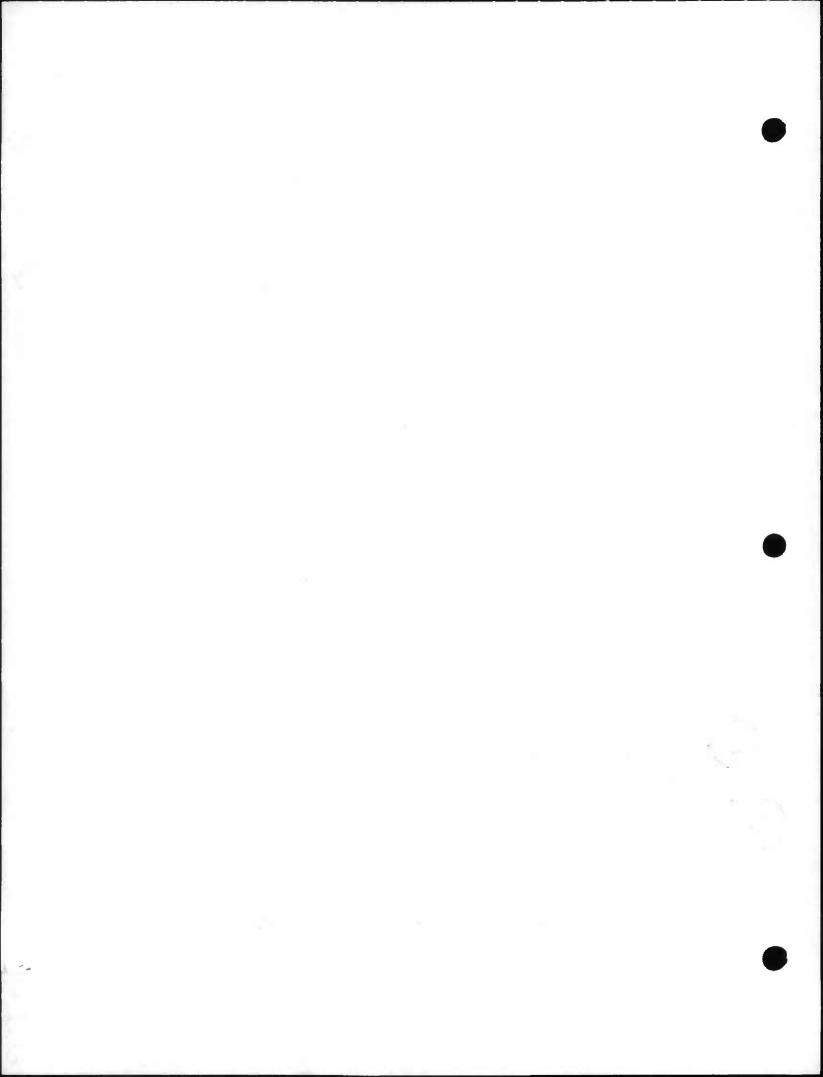
DIVISION OF VIT	DOCATED OF B PHYSICIAN:	DIRECTOR, Mer this certifical	The Start with the Start	item 28 is marked, or Ite
	TO THE HOSP T	TO THE FUNERA	be filed within 72	IMPORTANT: II

	1 - STATE REGISTRAR		CERTIF	TMENT OF	F DEATH	REG. NO		
10	1. DECEDENT'S NAME (First, Middle, Last)	RMES	FIORE			2. DATE OF DEATH MONTH D	AY 1	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	S SEX S AGE	ore				2-9	3 701
3	131-18-3495	1 🗌 M 2 🔀 F	In yrs. last birthday) 98 YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 12-25-189	4	BIRTHPLACE (State or For Country) ITALY
DIRECTOR	9a. FACILITY NAME (If not institution, give str HOLY CROSS HOSPI RESIDENCE OF DECEMENT			47	OR LOCATION OF DI	EATH		OMERY
) Di	10a. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR LOC	ATION	· · · · · · · · · · · · · · · · · · ·		10d, INSIDE CITY
	MARYLAND PRINC	E GEORGES		ADELPHI			T-122	1 VES 2 X
IERAL	1801 METTZERRO RO	AD			20783		USA	N OF WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes,	ECENDENT OF HISPAI apecify Cuban, Mexica ES 2 XNO Specif		27.7	I. RACE — American India Black, White, etc. Specify: CAUCASIAN
ETED	15. DECEDENT'S EDUC (Specify only highest grade of	completed)	16a. DECEDENT'S (Give kind of Ma. Do NOT u	work done during i		16b. KIND OF BU		
COMPLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	KITCHE	N WORKE	2	HOTEL		
BE CO	17. FATHER'S NAME (First, Middle, Lest) (1ST NAME UNOBTAI	NABLE) NEGRI				ME (First, Middle, Melden ME UNOBTAI		ANSELMI
70	190. INFORMANT'S NAME (Type/Print) FIONA FARRIS-TEA	TES	1			, VA 22508	m, State, Zip C	ode)
	20a. METHOD OF DISPOSITION 1	206.	PLACE AND DATE	OF DISPOSITION	Name of	DATE 20c. LO		y or Town, State
	21. SIGNATURE OF TUNERAL SERVICE LICE		Sh.	DEM.	AND ADDRESS OF FA	RAL HOMES,	INC	RIA, VA
	23. PART I. Enter the diseases, or complete the condition of the condition	omplications that caused list only one cause on each undirection.	I the death. Do sach line.			VIRGINIA 2 h as cardiac or reap		t, Approxima interval Be Onset and
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	anderse DUE TO JOH AS A	CONSEQUENCE OF	inte	den	whora	escul	las
MEDICAL C	PART II. Other significant conditions	contributing to death be	ut not resulting	in the underlyi	ng cause given in	Part I. 24s. WAS AN PERPOR	RMED?	24b, WERE AUTOPSY FIN MAILABLE PRIOR T COMPLETION OF CA OF DEATH? 1 YES 2 N
SICIAN:		HOSPITAL:		OTHER:	PLACE OF DEATH (Ch			
ву Рнуз	27. MANNER OF DEATH Maturel 5 Pending Investigation	28s. DATE OF HAJURY (Month, Day, Year)	28b, TIM	E OF 28c. F	UURY AT PORK? YES 2 NO	8 L) Other (Specify) 26d. DESCRIBE HOW I	NJURY OCCU	PRD .
ED	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Speci	At home, term,	lireet, factory, of	ice	28f. LOCATION (Street City or Revn. State)	and Number or	Plurel Plovite Number
4 2 4	294. CERTIFIER CERTIFYING PHYSIC	IAN: To the best of my knowle	edge, death occurr	ed at the time, de	te and place, and due	to the cause(s) and mar	vner ss stated.	
COMPLET		On the basis of equipmention				time, date and place, an	of due to the o	muse(s) and manner as sty

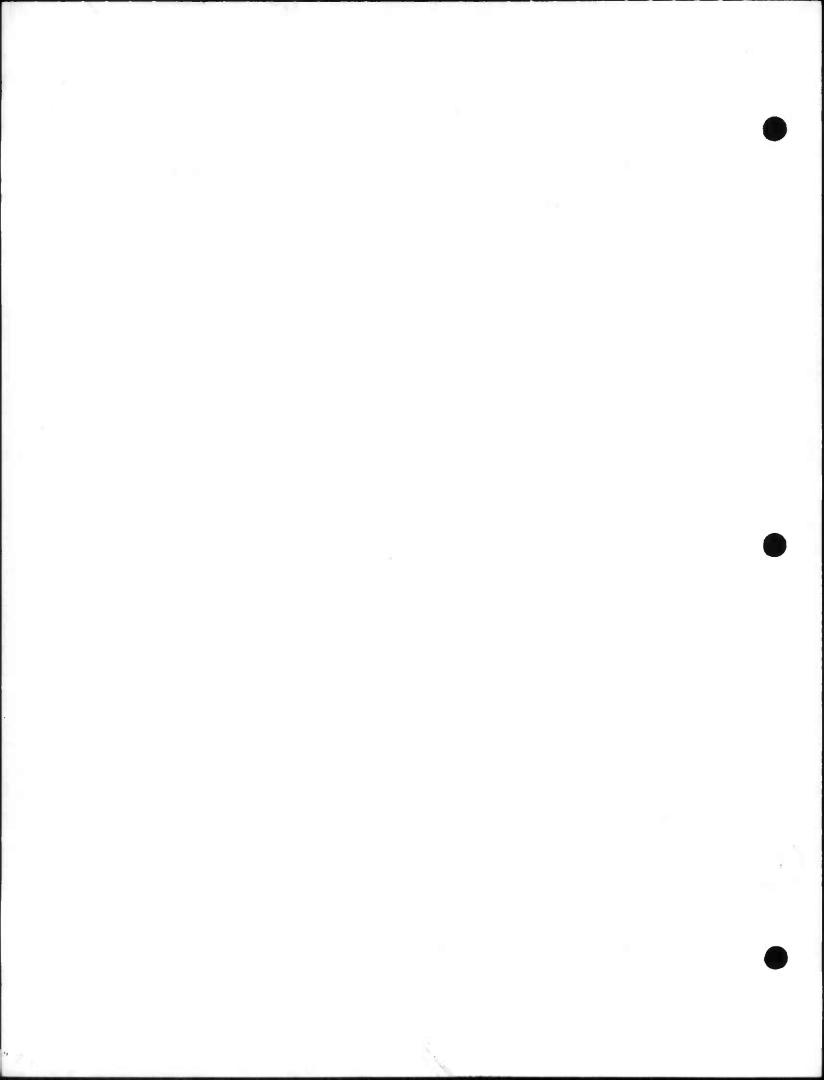
DO 2H MV 230;
32 ARGUSTRAN'S SIGNATURE
JUNE DEWYLDON FRINDSE

600

•93



	1 - FOR STATE REGISTRAR	STATE OF	MARYLAN	ND / DEPAR	RTMENT	OF H	IEALTH DEA	AND I	MENTA			3 0	8764
	1. DECEDENT'S NAME (First, Middle, Last)			De	- 2				MON	TH D		YEAR	. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In			t YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH		A. BIRTHPL	12:05 A.M. ACE (State or Foreign
	578 84 9945	1)∑ MM 2 □ F	34	YRS.	MONTHS	DAY8	HOURS	MIN.	րմեն	25,1	958W	ASHI	NGTON, D.C
·					9b. CITY,	TOWN C	R LOCATI	ON OF DE	EATH		9c. COU	NTY OF DEA	ТН
100	Prince George	s Hosp:	ital		Ch	eve	rly				Pr	ince	Georges
			ES					TS					Dd. INSIDE CITY LIMITS? YES 2 NO
RAL		- "- 0									10g. CITI	ZEN OF WH	AT COUNTRY?
뽕	6600 RONALD R	12 WAS DECEDE	NT EVER IN U	S. ARMED	113 1				NIC OBICI	M2 (Parally No.			A
₩	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES?	1 YES	2 NO	1	f yea, spe	ecify Cuba	n, Mexica	ın, Puerto	Rican, atc.)	or No-	Specify: BLA	White, etc.
ETEC	(Specify only highest grade	completed)		Ba. DECEDENT'S (Give kind of ille. Do NOT u.	work done of se retired.)	during mo	ON st of workin	ng	16	b. KIND OF BU	SINESS/INC	DUSTRY	
MP F	llth		"	LABOR	RER					RO	OFIN	G	
5 III		SR									Sumame)		
		FORD											S.MD
	20e, METHOD OF DISPOSITION 1/ Pauriet 2 Cremetion 3 Rem		20b. PL cemete	ACE AND DATE	OF DISPOSE	ITION (Na	me of		DAT	TE 20c. LO	CATION -	City or Town	State
	- marketing	ENSEE	_ H <i>E</i>	ARMONY									
	* Caepl	16)	Vill	lumo		517	7 11	th	STR	EET S.	E.		C
	index, or heart failura. immediate Cause (Final disease or condition requiring in death)	a. Mu	tise on each	lina.	Zun:						ratory arr	rest,	Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	2.	DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
	resulting in death) LAST	d,											
JICAL	PART II. Other aignificant condition	a contributing to	death but	not resulting	in the un	derlying	ceuse (ilven in	Part I.	PERFOR	MED?	C	ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?
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CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	11007:71					ACE DF D	EATH (Che	eck only o	ne)			
YS!	1 TWES 2 NO				4 🗆 Nurs	ing Home		sidence	_				
H	1 Netural 5 Pending	(Month, C	Day, Year)	INJ	JURY	WOI	RK?	I NO	26d. DE	SCRIBE HOW II	NJURY OCC	CURED	
اماه	3 Suicide 8 Could not be	28e. PLACE C	OF INJURY -	At home, ferm,				, NO	26f. LOC	CATION (Street a			te Number,
	AND CERTIFIED					-					-		ad
	(Check only	CIAN: To the best of R: On the besie of e	f my knowledg	ge, death occurrend/or investigation	ed at the til on, in my op	me, date pinion, de	end place, eth occur	and due	to the ca	use(e) end men e end place, en	ner as stated	ed. e cause(e) e	nd manner se stated.
8	Derm	2 1	Chus	f um	- W								The state of the s
16	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAU	SE OF DEATH	(ITEM 27) (Type,	, Print)			_					-
4 1			11	1 10	- 01					re, M			21201
If the marked at them 74 chaws and letter that mails also the mail the marked are	COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION TO BE COMPLETED	1. DECEDENT'S NAME (First, Middle, Last) RAYMOND 1. DECEDENT'S NAME (First, Middle, Last) RAYMOND 1. DECEDENT'S NAME (If not institution, give see the property of the pro	THE STATE IN THE PROPERTY SAME (First, Middle, Last) RAYMOND FORD SR 19. INFORMANT'S NAME (First, Middle, Last) PAY MOD BY MARKET OF DESCRIPTION SR 10. STATE 10. COUNTY MD PRINCE GEORGE 10. STATE 10. COUNTY MD PRINCE GEORGE 11. MARITAL STATUS 12. WAS DECEDENT'S IP YES, GIVE 13. DECEDENT'S EDUCATION (Specily only highest prade completed) 15. DECEDENT'S EDUCATION (Specily only highest prade completed) 17. FATHER'S NAME (First, Middle, Last) RAYMOND FORD SR 190. INFORMANT'S NAME (Type/Print) LILLIAN RENEA FORD 200. METHOD OF DISPOSITION STATE (Illura. List only one ce with the diseases or complications the highest of the course. Enter UNDERLYING 21. SHAWSTURE OF FUNERAL SERVICE LICENSEE 23. PART I. Enter the diseases, or complications the highest of the course. Enter UNDERLYING 21. SHAWSTURE OF FUNERAL SERVICE LICENSEE 23. PART II. Other aignificant conditions contributing to the course. Enter UNDERLYING 24. SOURCE (Disease or injury that initiated events resulting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 TYES 2 NO 1 Indicated the conditions contributing to the course. Enter UNDERLYING 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 TYES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicides 8 Could not be determined 29. SIGNATURE AND TITLE OF CERTIFIER (Check on) 2 MEDICAL EXAMINER: On the best of the course. CERTIFIER (Check on) 1 CERTIFIER (Check on) 2 MEDICAL EXAMINER: On the best of the course. CERTIFIER (Check on) 2 MEDICAL EXAMINER: On the best of the course. CERTIFIER (Check on) 1 CERTIFIER (Check on) 1 CERTIFIER (Check on) 2 MEDICAL EXAMINER: On the best of the course. 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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours atter dea	MERAL DIRECTOR: After this certificate has been signed by the attending physician and complexity filled in by the fu
1	-8	3

		1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL HYGIEN		00.700
		1. DECEDENT'S NAME (First, Middle, Last) NICHOLAS	I.		FIN	AMORE	2. DATE OF OEATH MARCH 09,		year 9:20 P
2		4. SOCIAL SECURITY NUMBER 577–56–6027	1 🗓 M 2 🗆 F 5	(In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	· ·	1942 Wa	BIRTHPLACE (State or Foreign Country) ashington, D.C
Š	DIRECTOR	90. FACILITY NAME (If not institution, give s 125 CHARLES PLA(CE (Residence	e)		OR LOCATION OF D N HEAD	EATH	9c. COUNTY CHAR	Y OF DEATH LES
3	Di li	10a. STATE 10b. COUNTY	,	10c. CIT	, TOWN DR LOCA	TION			10d, INSIDE CITY
3		Maryland Cha	rles		Indian H	lead			LIMITS?
	ERAL	125 Charles Pl	ace		10	20640		1100	N OF WHAT COUNTRY?
	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 X X X Y Y Y Y	II yes, sp	CENDENT OF HISPA	NIC ORIGIN? (Specify Yeen, Puerto Rican, atc.)		I. RACE — American Indian, Black, White, etc.
	9	15. DECEDENT'S EDU((Specify only highest grade	CATION	18e. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF BU	ISINESS/INDUS	Specify: White
	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	We. Do NOT us		ost of working	D71		
once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		Plumbe	21	44 1407115710 114	Pluml		
at or	- 1	Louis J. Finamo	m.c.			(ME (First, Middle, Meiden	,	
Pe	BE	19a. INFORMANT'S NAME (Type/Print)	re	405 MAILING	ADDRESS (Co		n L. Maddo		
notified	5	Phoenie C. Finamo	nre	1			an Head, N		
must be		20e. METHOD OF DISPOSITION	201	PLACE AND DATE O	F DISPOSITION (Na	ame of			y or Town, State
		1 X Buriel 2 Cremation 3 Remo	oval from State	netery, cremetory or oti esurrecti	on Ceme	terv 3	3/12/93 Cli		
il il	n I	21. SIGNATURE OF FUNERAL SERVICE LIE	ENSEE)		22. NAME AI	ND ADDRESS OF FA	CILITY		
si. examiner		* Alossox	Thale	1			as Funeral		Ma 20745
nation, or removal, the medical		23. PART I. Enter the diseases, or canock, or heart feliure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	List only one ceuse on e	ech line.	ot enter the mo	de of dying, suc	th as cerdiec or resp	riratory arrest	t, Approximete interval Between Onset and Death
burtal, crema	N	Samuel Malle Han and distance of the	DUE TO (DR AS A	CONSEDUENCE DE):				
giene prior to buria other traumatic	CATIC	Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A	CONSEQUENCE OF):				
主旨	CERTIFICATION	that initieted events resulting in death) LAST	DUE TO (OR AS A	CONSEDUENCE OF):				
d Menta Injury,		PART II. Other significent condition	e contributing to deeth b	ut not recuiting in	the underlying	ceuse given in	Part i. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
of Health and shows any in	MEDICAL					9 00230 91001 111	PERFOI	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
							-		1 TYES 2 NO
State Dept Item 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE DF DEATH (Ch	eck only one)		
The St	HYSI	1 TYES 2- NO	1 Inpatient 2 ER/Outp	nationt 3 DOA	OTHER: 4 Nursing Hom	e 5 Presidence	6 Other (Specify)		
ater death with 1 28 is marked,	ву Рн	27. MANNER OF DEATH 1. Netural 5 Pending 2 Accident Investigation	28e. DATE DF INJURY (Month, Day, Year)	28b. TIME INJU	JRY WO	URY AT PRK?	28d. DESCRIBE HOW I	NJURY OCCUR	RED
28 Hz	ETED	3 Suicide 8 Could not be 4 Homicide determined	26e. PLACE DF INJURY building, atc. (Spec	— At home, ferm, st	reet, fectory, offic	•	281. LOCATIDN (Street City or Town, State)	and Number or	Rural Route Number,
in 72 hours IT. II litem	MPL	29a. CERTIFIER Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my known: 3: On the basis of axamination	ledge, death occurre	d at the time, date	end place, end due	to the cause(a) and mai	nner as stated.	ause(s) end manner as stated.
IMPORTANT.	BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER	MM	'Alas		29c. LICENSE NUI		29d. DATE SI	IGNED (Month, Day, Year)
7	2	30. NAME AND ADDRESS OF PERSON WHO Krishan Mathur, M					.	nd 200	02
-,-		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE	Juille J	○⊃ MaT∏O	ii, maryia	110 206	003
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296. SIGNATURE AND TITLE OF CERTIFIER

7141 S 31 DATE FILED (MONTH, Day, Year) MAR 1 2 1993

TO BE

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		FOR STATE REGISTRAR			ENT OF HEALTH AND NATE OF DEATH	MENTAL HYGIENE 93	08766
		1. OECEDENT SMAME (First, Middle, Last)	Fem	i f		2. DATE OF DEATH	EVU OPLINE OR DEVLH
P		547-329979	5. SEX 6. AGE (In y)	NUS. MONT		12/1/28 3	BURTHPLACE (SUM OF FOREST) SCROOL TOWN . PA.
1, 2, 3 should	TOR	RESIDENCE OF DECEDENT	2009 M	71. OL 26.	CITY, TOWN OR LOCATION OF DE	ATH COUNTY	ALL COC
nit. Pages	DIRECTOR	10s. STATE 10s. COUNTY	Hond	10c. CITY, TO	WN OR LOCATION		10d. INSIDE CITY LIMITS? 1 YES 2 X NO
transit perm	FUNERAL	10% STREET AND NUMBER 1412 Ch EROK 11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. A	- OHED	10f. ZIP CODE	Un:	N OF WHAT COUNTRY? LEA STATES B. RACE — American Indian.
as the burial-transit permit. Pages	ВУ	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES 2 THE YES, GIVE WAR OR DATES		If yes, specify Cuban, Maxical 1 YES 2 NO Specify	n, Puerto Ricen, etc.)	Black, White, etc. Specify: White,
for use	PLETED	15. DECEDENT'S EDUC/ (Specify only highest grade of Elementary/Secondary (0-12)	completed)	Itle. Do NOT use retir	done during most of working red.)	16b. KIND OF BUSINESS/INDUS	STRY A
be detacher	E COMPI	17. FATHER'S NAME (First, Middle, Last)	WASSERMA	1		ME (First, Middle, Malden Surmame)	··ck
ige 5 should be notified	TO B	190. INFORMANT'S NAME (Type/Print)	MSKin	1412	Cherok	Route Number, City or Roun, Statu, Ze Co	Belaix Md.
director, pa		20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Permon 4 Donation 5 Other (Specify)	val from State	DE OF DISPOSITION Place)	N (Name of cernetery evernatory or	20c. LOCATION — CH	Auches Ca
the funeral oval. al examin		· Jane	ell Itum	t	1425 MA	trey mund Au	c. N.E.
nding physician and completely filled in by the funeral director, page 5 should be detached Hyglene prior to burial, cremation, or removal. It is not the traumatic event, the medical examiner must be notified at once.		IMMEDIATE CAUSE (Finel disease or condition	list only one cause on each fli	ne.			Approximete Interval Between Onset and Death
d completely urial, crema lic event,	z	resulting in death)	DUE TO GOR AS A CONS	lequence of:	any arres	<u>لا</u>	
hysician and e prior to b	TIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONS LAD ELL OUE TO (OR AS A CONS	1			
B - 0	E	that initiated events resulting in death) LAST	hyperti	nein			
th and	EDICAL	PART II. Other significant conditions	e underlying cause given in	Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
2 De	AN: M	25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATH (Ch	eck only one)	1 YES 2 NO
certificate h the State I	YSICI	EXAMINER?	HOSPITAL: 1 Inpetient 2 FR/Outpetient		HER: Nursing Home 5 - Residence	6 Other (Specify)	
harris ce marked,	ву РНҮ	27. MANNER OF DÉATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCU	
m 28 ts	OMPLETED	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At building, etc. (Specify)	home, ferm, street	I, factory, office	281. LOCATION (Street and Number of City or Town, State)	Rurel Route Number,
NERAL DI thin 72 hou NT: If Its	OMPL	one)				to the cause(a) and manner as stated time, date and place, and due to the	

DEATH (ITEM 27) (Type, Print)

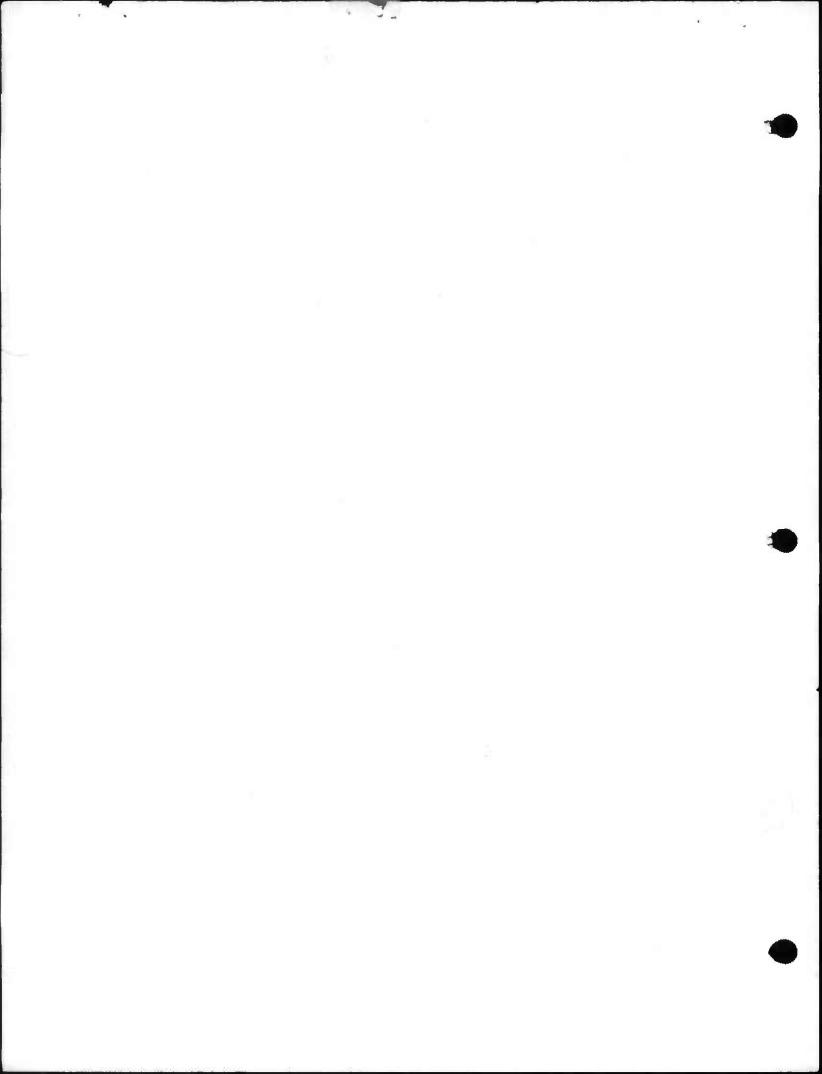
32. REGISTRAR'S SIGNATURE

29c. LICENSE NUMBER

Bultimore

29d. DATE SIGNED (Month, Day, Year)

3/10/63



e hosp	TO THE FUNE HAVING THE THIS CERTIFICATE has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached		IMPORTANT: Il liam 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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TO THE WASHING ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	funeral		xamin
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.	93	08767
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	1 - STATE REGISTRAR	STATE OF M	IARYLAND C	/ DEPAR	ICATE	OF H	EALTH	AND N	MENTAI	REG. NO		3 0	8/6/
- 3	1. DECEDENT'S NAME (First, Middle, Last)		····						2. DATE	OF DEATH			TIME OF DEATH
	John	Lewi	S	FLE	ISCH	MAN	5	Sr			24, 19	993	3:40 p M
		5. SEX	8. AGE (In yrs. 195		IF UNDER t	YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE (Month	DE BIRTH	1897	Mary	ACE (State or Foreign
	9e. FACILITY NAME (If not institution, give street	it and number)			9b. CITY,	TOWN O	R LOCATIO					Y OF DEAT	н
DIRECTOR	Homewood Retireme]	Fred	derio	k		· · · · · · · · · · · · · · · · · · ·	Fre	ederi	.ck		
2	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR							10	d. INSIDE CITY LIMITS?
	Maryland Frede	rick			Free	_							YES 2 NO
FUNERAL	31 West Patrick S	treet				101.	ZIP CODE					S.A.	T COUNTRY?
BY FU	1 Never Married 2 Married	2. WAS DECEOENT FORCES? 1 IF YES, GIVE W 0/10/19	YES 2	NO	11	yes, spe	ENDENT O	n, Mexicen	n, Puerto F	? (Specify Yellican, etc.)	or No 1	Black, W	American Indian, hite, etc. White
	15. DECEDENT'S EDUCAT	TION	16a. (DECEDENT'S	USUAL OCC				16b.	KIND OF BU	SINESS/INDU		WILLE
COMPLETED	(Specify only highest grade cor Elementary/Secondery (0-12)	mpleted) College (1-4 or 5+)		(Give kind of v fe. Do NOT us	work done du se retired.)	ring mos	it of workin	g					
鱼		2		Cleane	er & 1	Dyei	2		I	ry Cl	eanin	g	
ő	17. FATHER'S NAME (First, Middle, Last)						18. MOTN	ER'S NAM	ME (First, A	liddle, Maiden	Sumame)		
BE (John Henry	FLEISCH	MAN				Car	colir	ne	L.	B	AER	
일	19e. INFORMANT'S NAME (Type/Print)										n, State, Zip C		
-	John L. Fleischman	ı, Jr		515 P	ine L	ane,	, Los	Alt	tos,	Calif	ornia	940)22
	20e. METHOD OF DISPOSITION 1 X Burlai 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	il from State	206. PLAC cemetery, of MOUN	remetory or o	of Disposit	eme	neof tery	3/	1/19	20c. LO	cation – di cederi	ty or Town,	Maryland
	21. SIGNATURE OF TUNERAL SERVICE LICEN	SEE/			22. N	AME AN	D ADDRES	S OF FAC	YTLITY				
	Ketth hum t	Cohan	MC MC	00706							unera.		D 21701
	23. PART I Enter the diseases, or conshock, or heart feliure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	oue To (e on each iir	18.							ratory erres	st,	Approximata interval Between Onset and Daath
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONS	EOUENCE OF	F):								
ir l	that initiated events reaulting in death) LAST	DUE TO (OR AS A CONS	EQUENCE OF	F):		-						
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PHYSICIAN: MEDICAL	that initiated events resulting in death) LAST PART II. Other eignificant conditions of the condition	CONTRIBUTION TO CONTRIBUTION T	death but not	resulting i	OTHER:	26. PL/ ng Home 8c. INJL WOF	ACE OF DE	EATN (Chec	ck only one	PERFOR	MED?	CO OF	AILABLE PRIOR TO MPLETION OF CAUSE OEATH?
BY PHYSICIAN: MEDICAL	PART II. Other eignificant conditions of the con	OSPITAL: Inpetient 2 OF (Month, De	death but not	resulting 3 □ DOA 28b. TiMiNJ	OTHER:	26. PL/	ACE OF DE	EATN (Chec sidence 8	ck only one B Other 28d. OE\$	PERFOR	NJURY OCCU	AM CO OF 1 (NLABLE PRIOR TO MPLETION OF CAUSE OEATH? YES 2 NO
BY PHYSICIAN: MEDICAL	that initiated events resulting in death) LAST DART II. Other aignificant conditions of the condition	OSPITAL: Inpatient 2 28e. OATE OF I (Month, De	ER/Outpatient NJURY y, 'bear) INJURY — At 1 Inc. (Specify) my knowledge, o	3 DOA 28b. TIMI NJ DOMe, ferm, deth occurred	OTHER: 4 Number E OF 2 FURY M attreet, fector	26. PL/	ACE OF DE	EATN (Checo sidence 8	B Others 28d. OES 28f. LOCA City o	PERFOR 1 YES 2 (Specify) (Specify) (Sirect or Town, State)	NJURY OCCU	AM CO OF 1 (NLABLE PRIOR TO MPLETION OF CAUSE OCATH? YES 2 NO NO Number,
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BY PHYSICIAN: MEDICAL	that initiated events resulting in death) LAST DART II. Other aignificant conditions of the condition	OSPITAL: Inpatient 2 28e. OATE OF I 28e. PLACE OF building, e	ER/Outpatient NJURY y, 'bear) INJURY — At 1 Inc. (Specify) my knowledge, o	3 DOA 28b. TIMI NJ DOMe, ferm, deth occurred	OTHER: 4 Number E OF 2 FURY M attreet, fector	26. PL/	ACE OF DE	NO NO end due to at the true NSE NUMBER	281. LOCA City of the ceutime, dete	PERFOR 1 YES 2 (Specify) (Specify) (Sirect or Town, State)	NO NO NJURY OCCU	AMCOOFF 1 (NLABLE PRIOR TO MPLETION OF CAUSE OCATIF? YES 2 NO Number, Number, d manner ee stated.
BE COMPLETED BY PHYSICIAN: MEDICAL	that initiated events resulting in death) LAST DART II. Other eignificant conditions of the condition	OSPITAL: Inpetent 2 28e. OATE OF 28e. PLACE OF building, e	ER/Outpatient NJURY , vber/ INJURY — At a lote. (Specify) my knowledge, comination end/o	a DOA 28b. TIMI INJ	OTHER 4 Phursir E OF 2 FURY M 2	26. PL/	ACE OF DE	EATN (Check Sidence 8	281. LOCA City of the ceutime, dete	PERFOR 1 YES 2 (Specify) (Specify) (Sirect or Town, State)	NO NO NJURY OCCU	AMCOOFF 1 (NLABLE PRIOR TO MPLETION OF CAUSE OCATIF? YES 2 NO Number, Number,
COMPLETED BY PHYSICIAN: MEDICAL	that initiated events resulting in death) LAST DART II. Other aignificant conditions of the condition	DOORPITAL: Inpetient 2 28e. OATE OF I (Month, De building, e	ER/Outpatient NJURY — At Note. (Specify) my knowledge, comination end/o	3 DOA 28b. TIMM INJ	OTHER 4 Winding BOTHER 1 WINDING MINI	26. PL/ pg Home 8c. INJU 1 U Y y, office	ACE OF DE	end due t ed at the ti	286. LOCA City to the ceu- time, date	PERFOR 1 YES 2 (Specify) (Specify) CRIBE NOW II ATTOM (Street or Town, State) se(e) end managed place, end	NJURY OCCU	AMCOOFFICE OF THE STATE OF THE	MLABLE PRIOR TO MPLETION OF CAUSE OCATIV? YES 2 NO Number, Number, Manner ee steted.

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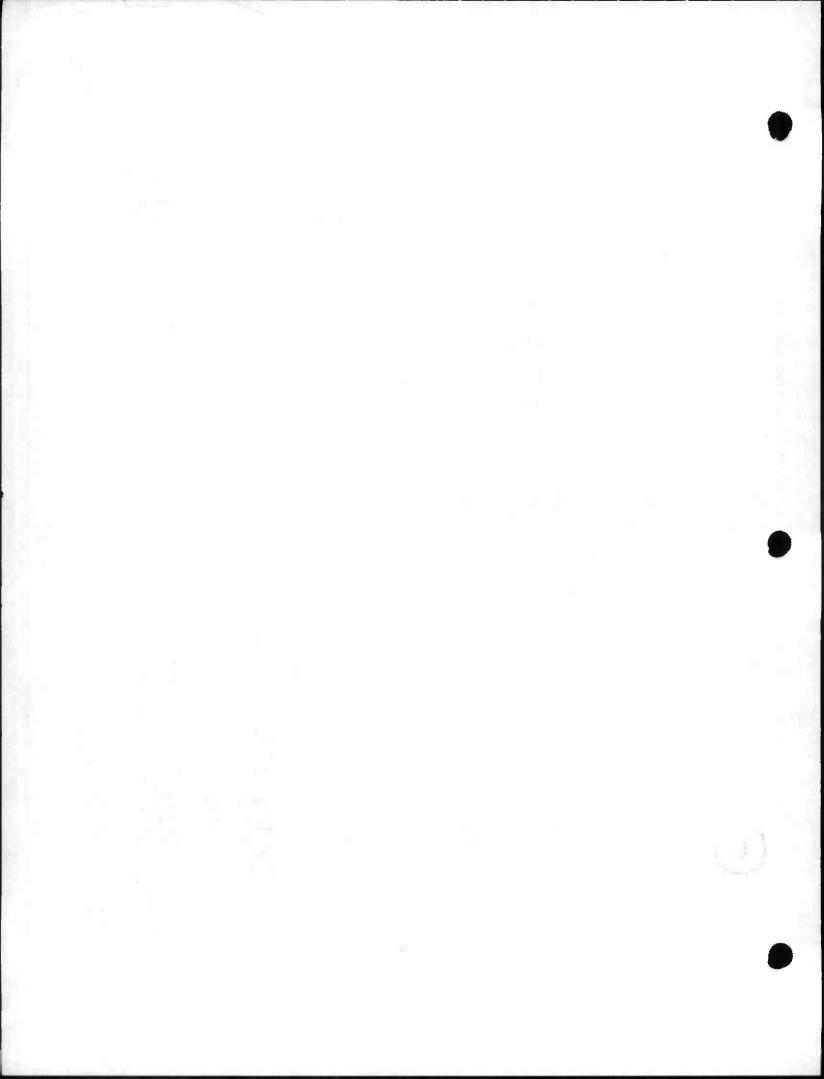
3 PHYSICIAN: The law requires that the death certificate be executed within 24 nouns after death, Page 6 may be retained by the hospital or attending physician.	HEATTH After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	remains after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	is its marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
CIAN: The	ertificate h	the State L	or item
VG PHYSIC	ter this ce	ath with t	marked,
NOWELLA BOARDIN	STOR A	all the de	28 is
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31. DATE FILED (MONTH, Day, Year)
MAR 1 7 '93

32. REGISTRAT'S SIGNATURE
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1 - STATE REGISTRA	3	OTALE OF T			ICATE OF		MENTAL HYGIEN REG. NO					
1. DECEDENT'S N	AME (First, Middle, La	ist)					2. DATE OF DEATH			TIME OF DEATH		
FLSI	E H. FL	EMING					T 1	Z X	1998	3.35pm		
4. SOCIAL SECUR		5. SEX	6. AGE (In yrs. I	last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		The state of	CE (State or Foreign		
	213-22-6680		□ M 2√ F 99		MONTHS DAYS	HOURS MIN.	07 24 189		Maryland			
WILLI	E (II not institution, gi	MANOR			96. CITY, TOWN EASTO	N MARY	MARYLAND 21601 TALBOT					
10a. STATE	10b. COL			10c. CIT	TY, TOWN OR LOCA		LIMITS?					
MARYLA	110	Caroline_					TISBOLO			YES 2 NO		
10e. STREET AND	NUMBER				10	of. ZIP CODE		10g. CI	TIZEN OF WHA	T COUNTRY?		
Main St	Main Street					21641			U.S.A.			
1 Never Marrie	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DATE				If yes, a		an, Puerlo Rican, etc.)					
((Specify only highest grade completed)				DENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUST kind of work done during most of working							
Elementary/Se	condary (0-12)	College (1-4 or 5	+)	ille. Do NOT u	NO.		******					
8 yrs.		None		H	omemaker	:	Home					
17. FATHER'S NAM	E (First, Middle, Last)						AME (First, Middle, Maide					
	James	Elijah Hi	cks			Le	llen S	anders				
19a. INFORMANT	S NAME (Type/Print)			19b. MAILING	AOORESS (Street	and Number or Rura	l Route Number, City or To	wn. State. 2	Zip Code)			
Laura Virginia Butler PO Box 1, Hillsboro, Maryland 21641												
1 KBurlel 2	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory, or other place) Greenmount Cemetery 3/17 Hillsboro, Maryland											
22. NAME AND ADDRESS OF FACILITY Moore Funeral Home, P.A. Drawer B, Denton, Maryland 21629												
23. PART I. En she immediate Cardisease or corresulting in de	USE (Final	· A	at caused the cuse on each lic	>	not anter tha m		ch se cardisc or res	piratory s		Approximate interval Betwee Onset and Deal		
if sny, leading cause. Enter U CAUSE (Disect that initiated a	Sequentially list conditions, if sny, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): c. OUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other	significant cond	itions contributing to	o death but no	t resulting	in the underlyi	ng cause given i	PERFORMED? 1 YES 2 NO OF DEATH?			ERE AUTOPSY FINDING MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO		
EXAMINER? 1 YES 2 27. MANNER OF	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 40. Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 286. OATE OF INJURY (Month, Day, Year) 287. MANNER OF DEATH 288. OATE OF INJURY TWORK?											
Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At h						YES 2 NO	281. LOCATION (Stree City or Town, Stat	t end Numl e)	ber or Rural Rou	te Number,		
29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner se stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 2												

606 REGHENNIS

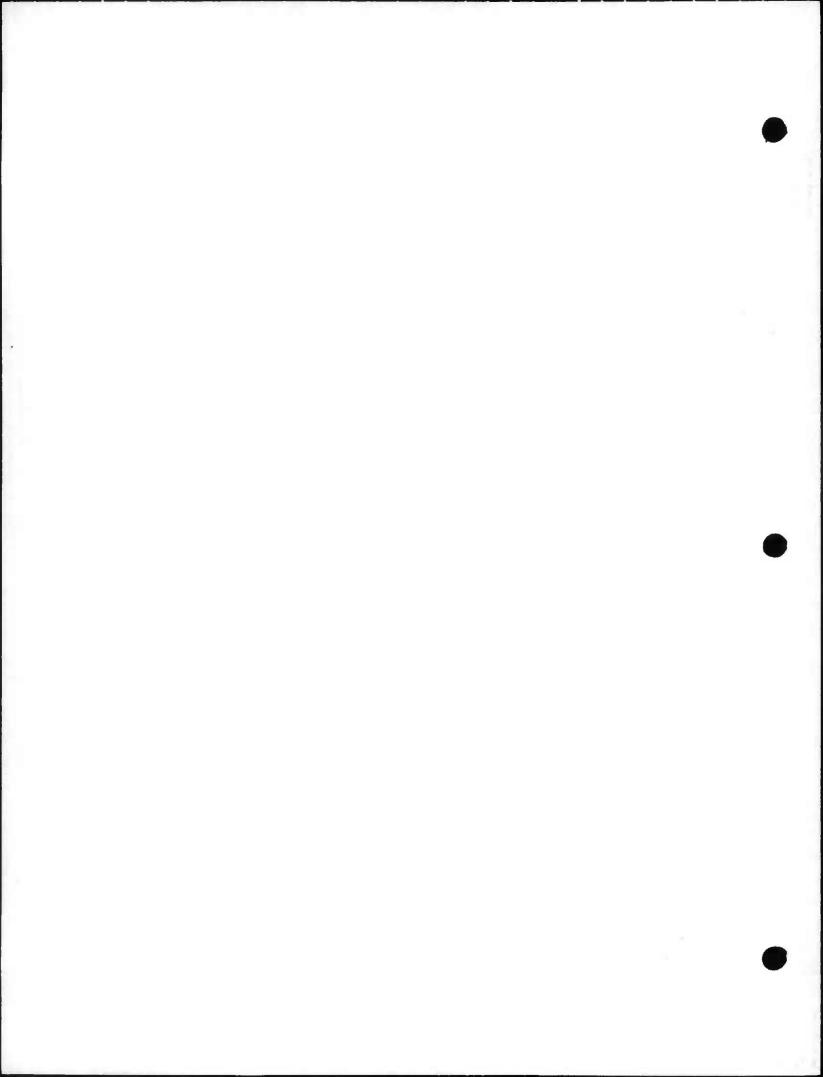


1 - FOR STATE REGISTRAR

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		712-010-110-01				OLITTI	TOAT		DEA	111	HEG.	NO.		
		1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH DAY NEAR											3. TIME OF DEATH	
	l ï	LAURA HOPE D. FULTZ 03NTM 10V 93AR 12:2										12:25A _M		
		4. SOCIAL SECURITY NUMBE	5. SEX 6. AGE (In yrs. last birthd			y) IF UNDER 1 YEAR IF UNDER 24 HRS.			7. DATE OF BIRTH 8. BIRT		a BURTHE	PLACE (State or Foreign		
		266-41-9574		1 M 2 F			MONTHS			Y	(Month, Day, Year)		Country)	
Pin													iana	
3 should	œ	Sa. FACILITY NAME (If not institution, give street and number)					9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF							
οĭ.	인	Homewood Retirement Center Williamsport Washington										ton		
	입	10a. STATE	10b. COUNTY	r		10c. C	TY, TOWN	OR LOC	ATION					10d, INSIDE CITY
Pages	DIRECTO	Florida												LIMITS?
permit.		10e. STREET AND NUMBER					t. L	_	erdal					1 YES 2 NO
E E	FUNERAL	TOOL STREET AND NOMBER						1	Of. ZIP COD	Æ		10g. CIT	IZEN OF WI	HAT COUNTRY?
DZO physician. burial-transit	W W		_					\perp					USA	
rial-1	5	11. MARITAL STATUS 1 Never Married 2 1	Mambal	12. WAS DECEDED FORCES?			13.				HC ORIGIN? (Specify III, Puerto Rican, etc.		14. RACE Black,	- American Indian, White, etc.
-AND 21215-0020 the hospital or attending physician, detached for use as the burial-tran once.	BY	3 Widowed 4 Divor		IF YES, GIVE					S 2 XNO					hite
as th	60			1										пте
LZ Jatt			highest grade		¹	(Give kind o	I work done		TION nost of worki	ing	16b. KIND OF	BUSINESS/IN	DUSTRY	
Tal A	"	Elementary/Secondary (0-	12)	College (1-4 or 5	+)		use retired.)							
AND he hospit detached once.	COMPLET					home	make	r				-		
the hose detach	8	17. FATHER'S NAME (First, Mic					18. MOTHER'S NAME (First, Middle, Maiden Surname)							
MAKYLAND retained by the hospit 5 should be detached notified at once.	ш	William S.		ger			Laura Malcolm							
MAKYL retained by 1 5 should be notified at	10 B	19a. INFORMANT'S NAME (Ty	pe/Print)			19b. MAILH	G ADDRES	S (Street	and Numbe	r or Rural I	Route Number, City or	Town, State, Zi	p Code)	
e 5 :	۱۲	Beverly Con	rad			1381	0 Pa:	rkla	and D	rive	, Rockvi	lle. M	d. 20	853
AE, page		20a. METHOD OF DISPOSITIO			20b. P	LACE AND DAT	F OF DISPO	SITION /A	Name of		DATE 20c	LOCATION -	City or Tow	n State
ALI INIORE, death. Page 6 may be funeral director, page i. examiner must be	1	1 😾 Burial 2 □ Cremetion 4 □ Donation 5 □ Other (oval from State	Cemete Re	ery, crematory o	other place	emet	terv		3-15	lagere	town	Maryland
Page Il dire	l î	21. SIGNATURE OF FUNERAL		CENSEE		114			AND ADDRE			agers	COWII,	Haryland
ALIIN death. Pag tuneral di i, comminer		. 7	. 1 7	Vestal	/		M	INNI	ICH F	UNER	AL HOME			
the the transfer of							4.	15 E	E. Wi	lson	Blvd., I	lagers	town,	Md. 21740
BALL INORE, 24 hours after death. Page 6 may be filled in by the funeral director, page ion, or removal.		23. PART i. Enter the dis shock, or he IMMEDIATE CAUSE (Find disease or condition	ert fellure.	complications the List only one car	use on eec	the death. Do	not enter	the m	ode of dy	ing, suc	h as cardiec or re	espiratory ar	rest,	Approximate Interval Between Onset and Death
od within 24 ompletely fille I, cremation, event, the		resulting in death)	7	a	100 40 4 6	CONSEQUENCE	ON	5						-
S 5 5 6				DOE 10	7 (ON AS A C	ONSECUENCE	or):							
OX 66 COU, s be executed within 2 sician and completely rior to burial, crematic traumatic event, th	RTIFICATION	Sequentially list conditions, Due to (or as a consequence of):												
or clan	F	If any, leading to immediate cause, Enter UNDERLYING										j ,		
ertificate be ng physician giene prior to other traur	윤	CAUSE (Disease or injur		c	OR AS A C	ONSEQUENCE	OF):							
g gerti	Ē	that initiated events resulting in death) LAST			DUE TO (OR AS A CONSEQUENCE OF):									
attend rtaf Hy	B			d										-
vice that the death certificate signed by the attending physical Health and Mental Hygiene private any injury, or other tr		PART ii. Other significar	nt condition	s contribuying to	death but	not resulting	in the u	nderlyii	ng cause	given in		AN AUTOPSY		WERE AUTOPSY FINDINGS
that the the the the the and the and In	EDICAL	CADU	do	201155								FORMED?		MAILABLE PRIOR TO COMPLETION OF CAUSE
signed Health and	8	1 - sh	60	en constant							1 U YE	2 NO		OF DEATH?
	Σ	-17447	CUSI	000				_						1 TES 2 NO
Las taw	A	25. WAS CASE REFERRED TO						_						
- F 2 % 5	SICIAN:	EXAMINER?	MEDICAL	HOSPITAL:	V25-111		26. PLACE OF DEATH (Check only one) OTHER:							
S derifficants the Strain in the Strain	YS	1 WES 2 ANO		1 inpatient 2			4 Nu		me 5 🗆 R	esidence	8 Other (Specify)			
S S S S	РНУ	27. MANNER OF DEATH		28a. DATE Of (Month, L			ME OF	28c. IN W	JURY AT		28d. DESCRIBE HO	W INJURY OC	CURED	
2 00 2	B		Pending Investigation				М	1 🗆	YES 2	NO				
10.25	0		Could not be	28e. PLACE (building	OF INJURY -	At home, farm	, street, fac	tory, offi	lca		26f. LOCATION (Str City or Town, S		r or Rural Ro	ute Number,
2 Fight 8	I	4 Homicide d	latermined	200							.,,			
Men and Men	Ľ	29a. CERTIFIER 1 CERTI	FYING PHYSI	CIAN: To the best of	f my knowled	ion, death occu	rred at the	Ime det	te and place	and due	to the cause(a) and	manner es ets	ted	
전 경인 표	COMPL	onel												and manner as stated.
HOS:	S	296. SIGNAPORE AND TOSE	-									_		
TO THE HOSPITAL. TO THE FUNEPAL. TO FINE WITHIN 72 P. IMPORTANT: II	BE	AND SHOPAPORE AND SISEE	OF CERTIFIES	X /	200				39C. LIC	ENSE NUA	ABER	29d. DAT	TE SIGNED	Month, Day Your)
₽₽8₩	2	////	(//	1/1/	0_	<u></u>	<u> </u>		147	20	800		10	110
	-	To MANUE AND ADDRESS OF BERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												
		AlaunDermiseria (Caktall Die Hagertander)42												
	-	M. DATE FILED (Month, Day, Y		32. REGISTRA	AR'S SIGNAT	URE		-	100					
		MAR 15 199	3	Taki Sinie		4.44								



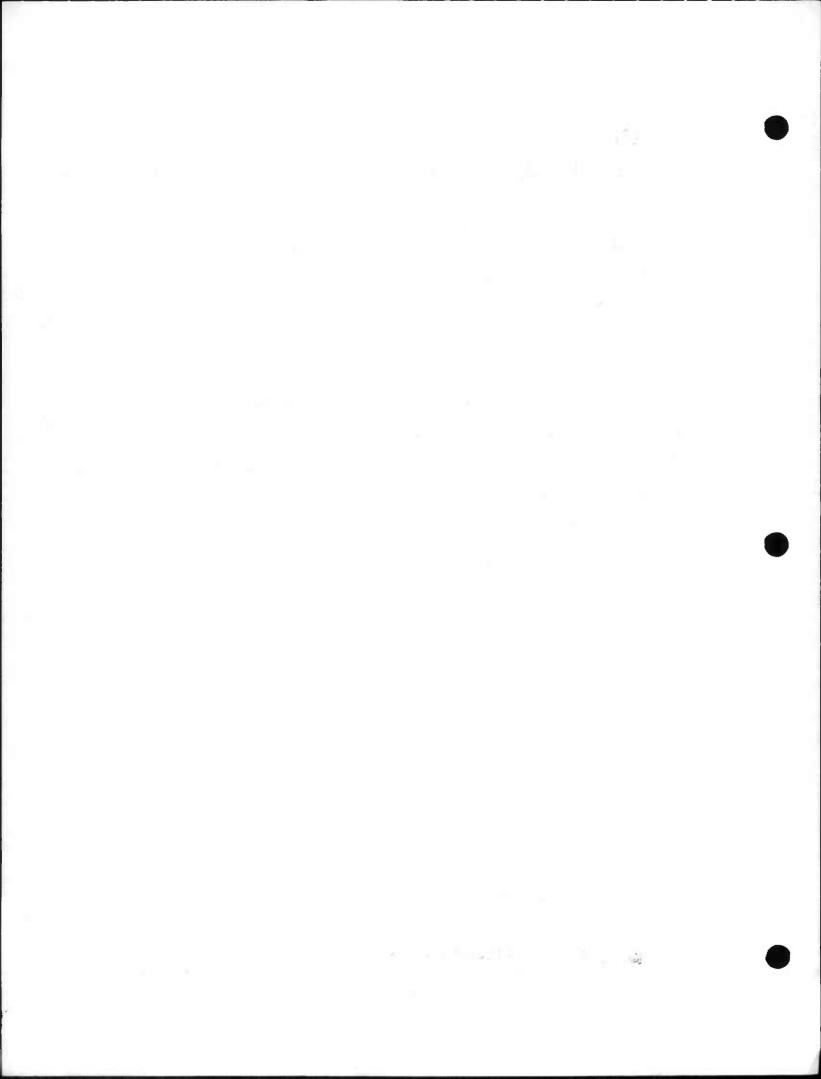
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THE HOSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

NOTHE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAND / DEPAR CERTIF	RTMENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Lest)	-05que		2. DATE OF DEATH MONTH 3 DAY 5 93 045 M							
DIRECTOR	2147053011	6. AGE (In yrs. last birthday) M 2 G F 3 6 YRS.	F UNDER 1 YEAR F UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 8.	BIRTHPLACE (State or Foreign Country)						
	9a. FACILITY NAME (If not institution, give stree THE JOHNS HOPKINS		BALTIMORE CITY		MORE CITY						
	10a. STATE 10b. COUNTY	MENCY 10c. CIT	TY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?						
FUNERAL D	10e. STREET AND NUMBER An T = 38 S	Somers Cove	10f. ZIP CODE	10g. CITIZEI	1 2 YES 2 NO						
		2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPAN If yes, specify Cuben, Mexicar	, Puerto Rican, etc.)	. RACE — American Indian, Black, White, etc.						
ED BY	3 Wildowed 4 Divorced 15. DECEDENT'S EDUCAT (Specify only highest grade cor	1974 TION 160. DECEDENT'S	1 YES 2 NO Specify USUAL OCCUPATION work done during most of working	16b. KIND OF BUSINESS/INDUS	Specify: B/ACK						
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +) life. Do NOT u	A BOVET	SEAFOO	d						
BE CO	17. FATHER'S NAME (First, Middle, Last)	G. STErling	18. MOTHER'S NAI	AE (First, Middle, Maiden Surname)							
10	Emily F. BYK	gory Apt-	38 Somers Cove	oute Number, City or Town, State, Zip Co	Eld md,						
	29s. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	cemestry, crematory or of	OFDISPOSITION (Name of other olgon) LEME ATU 3.	DATE 20c. LOCATION - CH	or Town, State						
	21. SIGNATURE OF FUNERAL SERVICE LICEN	· Mare	314 COURST	Cristield M	Nd, 21817						
	snock, or neert failure. Lis	nplications that caused the death. Do at only one cause on each line.			Approximate intervel Between						
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	DUE AD (OR ASIA CONSCIUENCE O	10		Onset and Death						
NO.	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUENCE O	n:		Queeks						
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSEQUENCE O	melanoma		2 months						
CERI	resulting in death) LAST										
MEDICAL	PART II. Other algniticent conditions of	contributing to death but not resulting	in the underlying cause given in i	Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?						
N: ME				_	1 - YES 2 NO						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1	OSPITAL: Vinpetient 2 - ER/Outpatient 3 - DOA	26. PLACE OF DEATH (Che OTHER: 4 Nursing Home 5 Residence (
ву РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year) 28b. TIM	E OF 28c. INJURY AT WORK? M 1 YES 2 NO	26d. DESCRIBE HOW INJURY OCCUP	NED						
	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY — At home, farm, building, etc. (Specify)	street, factory, offica	261. LOCATION (Street and Number or City or Town, State)	Rural Route Number,						
COMPLETED	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end dua to the cause(a) and manner as stated. Discretely the control of the cause(a) and manner as stated.										
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	March MD	29c. LICENSE NUM	BER 29d. DATE S	GNED (Month, Day, Year)						
10	30. NAME AND ADDRESS OF PERSON WHO C	90 CON N. 111	btpst Tohns A	LOKIOS HASO BO	Home 21287						
	31. DATE FILED (Month, Day, Year) MAR 9 '93	32. REGISTRAR'S SIGNATURE	2	The state of the							



TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

	IR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any contract after death. Page 6 may be retained by the hospital or attending physician.	INECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	vurs after death with the State Dept, of Health and Mantal Hyglene prior to burial, cremation, or removal,	em 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	DESITAL DR ATTENDING PH	INFAL DIRECTOR; After this	Fin 72 hours after death w	INT: If item 28 is mark
1	TO THE	10 THE P	De filed a	IMPORT

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AN	ND MENTAL HYGIENE
CERTIFICATE OF DEATH	REG NO

REGISTRAR	CERTI	FICATE OF	DEATH		REG. NO.				
1. DECEDENT'S NAME (First, Middle, Last)		17 H 74		2. DATE O	F DEATH DA	v	YEAR	3. TIME OF DEATH	
Alice Mab	e1 F	FEATHER		March		1993	TEAR	7:00 p. M	
4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. last birthda		IF UNDER 24 HRS.	7. DATE O	F BIRTH		8. BIRTHI	PLACE (State or Foreign	
234-82-7878 1 □ M 2 🖔	F 79 YRS	MONTHS DAYS HOURS MIN. (Month, Dey, Year) Country) Oct. 2, 1913 West Vi						t Virginia	
9a. FACILITY NAME (If not institution, give street and number		9b. CITY, TOWN	OR LOCATION OF D			9c. COUN			
Garrett County Memorial	Hospital	Oak	land				Garro	ett	
RESIDENCE OF DECEDENT							Jarr		
10e. STATE 10b. COUNTY	10c. 6	CITY, TOWN OR LOCA	TION					10d. INSIDE CITY LIMITS?	
West Virginia Preston Aurora 1□ yes 2 屎 N									
10a. STREET AND NUMBER		11	1. ZIP CODE			10g. CITIZ	EN OF W	HAT COUNTRY?	
Rt. 1 Box 343			26705				JSA		
	DENT EVER IN U.S. ARMED 1 YES 2 X NO		CENDENT OF HISPA pecify Cuban, Mexic			or No-	14. RACE Bleck	American Indian, White, atc.	
3 Widowed 4 Divorced	VE WAR OR DATES		S 2 X NO Speci				Specif	- 1	
15. DECEDENT'S EDUCATION	16. DECEDEN	T'S USUAL OCCUPAT	ION	105	KIND OF BUS	INIEGO (INIDI		White	
(Specify only highest grade completed)	(Give kind	of work done during in T use retired.)	ost of working	100.1	KIND OF SUS	MICSS/IND	JSINY		
Elementary/Secondary (0-12) College (1-4 o	or 8+)	sewife				Home			
17. FATHER'S NAME (First, Middle, Last)	1 100	isewile	18. MOTHER'S N	AME (SIL) M	felella Africiana		-		
Charles Luther	Blamble		Esthe			-	т.	: 11	
19a, INFORMANT'S NAME (Type/Print)		ING ADDRESS (Street			0.			iller	
Willard J. Feather								0.5	
20a. METHOD OF DISPOSITION		1 Box 34 POSITION (Name of co				CATION — C			
1 X Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	other place)								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Maple 5	pring Cen	ND ADDRESS OF F		IEGI	on, w	est	Virginia	
7 11. 41 0-	+		art Fune		ome				
Tranklin N. Cus	er	32 9	South Sec	ond S	treet	0ak1	and.	MD 21550	
23. PART i. Enter the diseases, or complications shock, or heart failure. List only one		o not enter the m	ode of dying, su	ch ea cardi	ac or respi	ratory erro	est,	Approximete interval Between	
IMMEDIATE CAUSE (Fine)	Couse on each line.							Onset and Death	
disease or condition resulting in death)	Acute and Ch	ronic Ren	nal Failu	ire				1 month	
	TO (OR AS A CONSEQUENCE	E OF):							
C 6.	Chronic Cong	estive He	eart Fail	Lure				Years	
If any, leeding to immediate	TO (OR AS A CONSEQUENCE	E OF):							
cause. Enter UNDERLYING CAUSE (Disease or tnjury	Diabetes Mel	litus						Years	
that initiated events	TO (OR AS A CONSEQUENCE	E OF):							
d.	resulting in death) LAST								
PART II. Other significant conditions contributing	g to death but not resultir	ng in the underlyi	ng cause given in	Part I.	24a, WAS AN		24b.	WERE AUTOPSY FINDINGS	
Dementia, Hypertensic	n, Anemia				PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
					1 YES 2	XNO		DF DEATH?	
								1 TYES 2 NO	
25. WAS CASE REFERRED TO MEDICAL		20.1	PLACE OF DEATH (C	back anti-ane					
	2 ER/Outpetient 3 DO								
			me 5 Residence		(Specify)	N BIRV OCC	HIBEO		
	th, Day, Year)	INJURY W	YES 2 NO	200. 000	UNIDE NOW I	NOON OCC	ONLO		
Z Accident Investigation	CE OF INJUSTY — At home for			284 1.004	TION (Street	and Mumber	or Present C	houte Alumbar	
3 Suicide 8 Could not be built	3 Suicide 8 Could not be 4 Homicide determined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER A V COMPANIA PURPLEMENT TO A STATE OF THE PURPLEMENT TO A S									
(Check only									
2 MEDICAL EXAMINER: On the basis	of axamination and/or investig	etion, in my opinion,	death occured at th	e time, data :	and place, an	d due to th	e cause(a) and manner as stated.	
296. SIGNATURE AND TITLE OF CERTIFIER	0 1/		29c. LICENSE NO					(Month, Day, Year)	
1 migaret	U Paux	~	D266	50		▶ 3	/16/	93	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED	CAUSE OF OEATH (ITEM 27) (1	Type, Print)							
Margaret A. Kaiser MD	PO Box 486	Oakland.	MD 215	50					
31. DATE FILED (Month, Day, Year) 32. REGI	STRAR'S SIGNATURE								

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WE I	o ha
The	64 0
THE HANNIAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page	MEDAL DIDECTION After this partitions has been signed by the otherwise one completely filled in the function of
PHY	ohio
DING	Attor
ATTEN	duma
DR	g
MA	MEDA
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Tage 6 may be retained by the hospital or attending physician. director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should DIVISION OF VITAL RECORDS, P.O. BOX 68760,

The PATAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp that the completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATH		3. TIME OF DEATH
	MAX GARCHI	K				MONTH 3	DAY	9	856 P "
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (I	In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF E (Month, De	BIRTH	8.1	BIRTHPLACE (State or Foreign Country)
	213-38-3786 19a. FACILITY NAME (If not institution, give stree	1 XM 2 F 7	6 YRS.	MONTHS DAYS	HOURS MIN.	JUNE 1	6,191	6 COUNTY	NEW YORK
DIRECTOR	HOLY CROSS HOSP	ITAL		R SPRING			2	TGOMERY	
EC	10a. STATE 10b. COUNTY	Y, TOWN OR LOCAT	ION				10d. INSIDE CITY		
	MARYLAND MONT	ILVER SP	RING			A- OFFICEN	LIMITS? 1X YES 2 NO OF WHAT COUNTRY?		
FUNERAL	11108 DODSON		20902		"		ED STATES		
S	11. MARITAL STATUS	2. WAS DECEDENT EVER IN FORCES? 1V YES IF YES, GIVE WAR OR DA		13, WAS DEC	ENDENT OF HISPAN			No- 14.	BACE — American Indian.
BY F	1 Never Married 2 📉 Merried 3 Widowed 4 Divorced		2 NO Specify		1, etc.)		Black, White, etc. Specify: WHITE		
ED	15. DECEDENT'S EDUCAT (Specify only highest grade co.	TION		USUAL OCCUPATIO		16b. KIN	D OF BUSINE	ESS/INDUST	
COMPLETED	Elementary/Secondary (0-12)	work done during mo: se retired.)	st of working	1 -					
MP		EMENT		U	S. G	OVERN	MENT		
8	17. FATHER'S NAME (First, Middle, Last)		16. MOTHER'S NA		s, Maiden Sun	name)			
JACUB GARCHIK IDA KATZ									
5	19a. INFORMANT'S NAME (Type/Print) BERNICE GARCHII	K		DODSON L					YLAND 20902
- 8	20e METHOD OF DISPOSITION 1 ABurial 2 Cremation 3 Remova	al from State 20b.		OF DISPOSITION (Na		DATE	20c. LOCAT	ION — City	or Town, State
	4 Donation 4 Other (Specify)	hor	DEAN" MEM	ORTAL GA		3/9			ARYLAND
	21. DIGHATURE OF FUNERAL SERVICE LICEN	Ties-		DANZA	NSKY-GOL	DBERG	MEMOR	LAL C	HAPELS, INC. LE,MD. 20852
	23. PART /. Enter the diseases, or con	Aplications that ceused	the death, Do r						
	the state of the s								
	The state of the s	nt only one cause on ea	nch line.	Tot dila tila tila	ue or dying, suc	ir as cardiac	or respirate	ory arroat,	interval Between
	IMMEDIATE CAUSE (Finel	it only one cause on ea	ich line.					ory arreat,	
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	CHRONIC DUE TO (OR AS A	CON (YE	STUNE !	to Art	PAILUR		ory arreat,	interval Between
NOI	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	CHRONIC DUE TO (OR AS A COROLLAM	CON (YE	TERLY	to Art	PAILUR		ory arreat,	interval Between
CATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	CHRONIC DUE TO (OR AS A COROLLAM	CON CE CONSEQUENCE OF	TERLY	to Art	PAILUR		ory arreat,	interval Between
TIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	CHRONIC DUE TO (OR AS A COROLLAM	CONSEQUENCE OF	SSTUME 1 FI: TEXLY S	to Art	PAILUR		ory arreat,	interval Between
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A.	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A	CONSEQUENCE OF	FISTURE !	tome of	Part I. 24a	. WAS AN AUT	TOPSY D?	Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE
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BE COMPLETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the conditions of th	DUE TO (OR AS A DUE TO	CONSEQUENCE OF CONSEQ	F): 26. PL OTHER: A Normaling Home E OF 28c. INJI WOI Y street, factory, office ad at the time, date on, in my opinion, de	Cause given in ACE OF DEATH (Chi 5 Residence URY AT RK? (ES 2 NO	Part I. 24a 1 [Bock only one) 8 Other (Sp 28d. DESCRIE 28l. LOCATIO City or To to the cause(e lime, date end	ecity) N (Street and demander place, end demander place)	TOPSY D? NO NO Number or A rea stated. ue to the ca	Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO BUT Route Number, Use(e) and manner ee stated. SINED (Month, Day, Year)
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BE COMPLETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions of the conditions of th	DUE TO (OR AS A DUE TO	CONSEQUENCE OF CONSEQ	F): 28. PL OTHER: 4 Nursing Home E OF 28c. INJURY WOO I Y street, factory, office ed at the time, date in, in my opinion, de	Cause given in ACE OF DEATH (Chi 5 Residence USY AT RK? ES 2 NO end place, and dua seth occured at the	Part I. 24a 1 [sck only one) 8 Other (Sp 28d. DESCRIE 28l. LOCATIO City or To to the cause(e lime, date end	ocity) N (Street and wn, State) end manner place, end de	Number or A as stated. use to the ca ad. DATE Sid.	interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO Bural Route Number, SNED (Month, Day, Year) 7. 9 3

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Market Co.

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Pages 1, 2, 3 should

DIRECTOR

1 - FOR STATE REGISTRAR

DECEDENT'S NAME (First, Middle, Last)

Suburban Hospital

9e. FACILITY NAME (If not institution, give street and number)

10b. COUNTY

5. SEX

1 X XM 2 | F

4. SOCIAL SECURITY NUMBER

578-03-3768

RESIDENCE OF DECEDENT

The street and Number 4 Bouic Circle 11. MARRITAL STATUS 1 Never Married 2XXXMerried 12. WAS DECED FORCES? 11. Never Married 2XXXMerried 12. WAS DECED FORCES?	Maryland Montgomery									
4 Bouic Circle	10e. STREET AND NUMBER									
	4 Bouic Circle									
11. MARITAL STATUS 12. WAS DECED	ENT EVER IN U.S. A	. ARMED 13. WAS DECENDENT OF HISPANIC ORIG								
9 g å	★♥ YES 2 □ E WAR DR DATES & Korea	,,,,,		pecify Cuben, Mexic S 2XXND Speci						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or	- (ECEDENT'S USL Give kind of work	done during m	ON ost of working	16b. I					
College (1-4 or	5+)	Dlan+	Engin	oor						
12 17. FATNER'S NAME (First, Middle, Last)		TTanc	Budin	16. MOTNER'S N.	AME (First Mi					
William F. Getting	Js				lian					
190. INFORMANT'S NAME (Type/Print) Mildred F. Gettings	19	96. MAILING ADI	DRESS (Street	end Number or Rural	Route Numbe					
- " - MITUIEU F. GELLINGS	4	Bouic	Circl	e, Rockv	ville,					
1 N Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cemetery, cr	remetory or other plans. Men	plecel	eme of Park 3/	0ATE					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				ND ADDRESS OF F						
21. SIGNATURE OF PUNERAL SERVICE LICENSEE 22. SIGNATURE OF PUNERAL SERVICE LICENSEE 23. PART I. Enter the diseases, or complications to	MO03		Rockv	Rockvill	rylan					
23. PART I. Enter the diseases, or complications to	hat coused the d	lesth. Do not	enter the me	ode of dying, su	ch ss cardia					
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Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING	TO (DR AS A CONSE	EDUENCE OF):	4	OF OF	1					
If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated exercise)										
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE 1 C. DUE 1 DUE 1	that initiated events DUE TO (DR AS A CONSEDUENCE OF):									
of the state of th										
PART II. Other eignificant conditions contributing	to deeth but not	resulting in th	ne underlyin	g ceuse given in	Part I.					
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A v requires been sign by the										
A 10 CC C VANAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 1 OK INDICAL INC. 1 OK Input long 2			26. P	LACE OF DEATH (CI	heck only one)					
EXAMPLE 1 D SPITAL: 1 YES 2 NO 1 D SINGERIA 27. MANNER OF DEATH 28. QATE I	ER/Outpatient		THER:	ne 5 🗆 Rasidence						
	DF INJURY Day, Year)	26b. TIME OF		JURY AT						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 1 TO SPITAL: 1 VES 2 NO 1 TO SPITAL: 27. MANNER OF OBATH 28. OATE 28. OATE (Month,			***	ORK?	28d. DESC					
27. MANNER OF OEATH 28s. OATE (Month, 1 New York 27. MANNER OF OEATH 28s. OATE (Month, (Month, 1 New York 20 Accident Investigation			M 1 🗆	YES 2 ND						
Z DN Light E 2 Accident Investigation	DF INJURY — At he	ome, farm, stree	M 1 🗆	YES 2 ND	28d. DESC 281. LOCAT City or					
A Surface Continue	ig, atc. (Specify)		M 1	YES 2 ND	261. LOCAT					
A Surface Continue	of my knowledge, de	eath occurred at	M 1	YES 2 ND	26t. LOCAT City or					
TO THE CONTROL OF CERTIFIER Control of the contr	of my knowledge, de	eath occurred at	M 1	YES 2 ND	261. LOCAT City or					
The state of the s	of my knowledge, d	eath occurred at	M 1 It, factory, office the lime, date or my opinion, or	YES 2 ND e a end place, end duit death occured at the	261. LOCAT City or					
The state of the s	of my knowledge, de	eath occurred at	M 1 It, factory, office the lime, date or my opinion, or	YES 2 ND e a end place, end duit death occured at the	261. LOCAT City or					
A Coldent Survival Su	of my knowledge, d	eath occurred at	M 1 It, factory, office the lime, date or my opinion, or	YES 2 ND e a end place, end duit death occured at the	261. LOCAT City or					

08773 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 9 3
CERTIFICATE OF DEATH
REG. NO. 2. DATE OF DEATH MONTH 3. TIME OF DEATH 93 6:00 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTNPLACE (State or Foreign Country) April 3,1917 Maryland 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Montgomery 10d. INSIDE CITY LIMITS? 1 X YES 2 | NO 10g. CITIZEN OF WHAT COUNTRY? United States IN? (Specify Yee or No — Rican, etc.) 14. RACE — American Indian, Black, White, etc. White b. KIND OF BUSINESS/INDUSTRY N.I.H. Middle, Maiden Sumeme) McGaha nber, City or Town, State, Zip Code) Maryland 20850 20c. LOCATION — City or Town, State Rockville, Maryland obert A. Pumphrey Funeral nc., 300 W.Montgomery Ave rdiac or respiratory srrest, Approximate Interval Between Onset and Death 6 mo

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

er (Specify) SCRIBE HOW INJURY OCCURED CATION (Street and Number or Rural Route Number, y or Town, State)

tuse(a) end menner as stated. a and place, and due to the couse(s) and menner as stated.

24s. WAS AN AUTOPSY PERFORMED?

29c. LICENSE NUMBER	29d. DATE SIGNED/Month, Day, Y

INGS

IF UNDER 1 YEAR

10c. CITY, TOWN OR LOCATION

IF UNDER 24 HRS.

Bethesda

8. AGE (in yrs. last birthday)

75

FOR STATE REGISTRAR

CERTIFICATE OF DEATH 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR MARCH 15, ALDO GILIOTTI 1993 8:20 P M 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year DAYS HOURS 1 🗔 M 2 🗌 F MAY 10, YRS. 577-52-9078 ITALY 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR 707 FOREST GLEN ROAD SILVER SPRING MONTGOMERY 10e. STATE 10b. COUNTY 19c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY SILVER SPRING 1 YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? USA 707 FOREST GLEN ROAD 20901 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- RACE — American Indian, Black, White, etc. 1 Never Married 2 X Marrie If yes, specify Cuben, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: IF YES. GIVE WAR OR DATES ΒY Specify: 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) MASONARY WORK MONTGOMERY COUNTY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BE ALFONSO GILIOTTI SANTINA SCAGNELLI 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 NAZZARENA FOREST GLEN ROAD SILVER SPRING, MARYLAND 20901 20a_METHOD OF DISPOSITION
1 ABurlal 2 Cremation 3 Ram 20b. PLACE AND DATE OF DISPOSITION (Nama of 20c. LOCATION — City or Town, State OATE 4 Donation 5 Other (Specify) GATE OF HEAVEN CEMETERY 3/19 SILVER SPRING, MARYLAND 21. SIGNATURE OF FUNERAL SERVIPE LICENSEE 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. teven 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901 23. PART I. Enter the diseasea, or complications that caused the daeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate ehock, or heart fallura. List only ona cause on each line. Interval Between **IMMEDIATE CAUSE (Finel Onset and Death** disease pr condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditiona, QUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediata ceuse. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF) thet initiated events resulting in death) LAST PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 NO OF DEATH? 1 TYES 2 T NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL OTHER: 1 YES 2 100 1 | Inpetient 2 | ER/Oulpetient 3 | DOA 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO B 2 Accident 26a. PLACE OF INJURY — Al home, farm, atreet, factory, offica building, etc. (Specify) 3 Suicide ETED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 29s. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. COMPL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER 022 77 13-16-5 9

CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAT'S SIGNATURE

5454 WISCONSIN AVE.#835

BARR

,d3

31. DATE FILED (Month, Day, Year)
MAR 17 '9

M.D.

attending physician and Hygiene prior to THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be Injury. is has been signed by the E Dept. of Health and Min 23 shows any inju t: After this certificate has r death with the State De is marked, or item 2 THE FORESTAL OR ATTENDING THE FUNERAL DIRECTOR: A! THE FUNERAL DIRECTOR: A! THE FORESTANT: If Item 28 IS I 69

use as the burial-transit permit. Pages 1, 2, 3 should

Por

the funeral director, page 5 should be detached

filled in by

i and completely filled to burial, cremation, c

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executed within

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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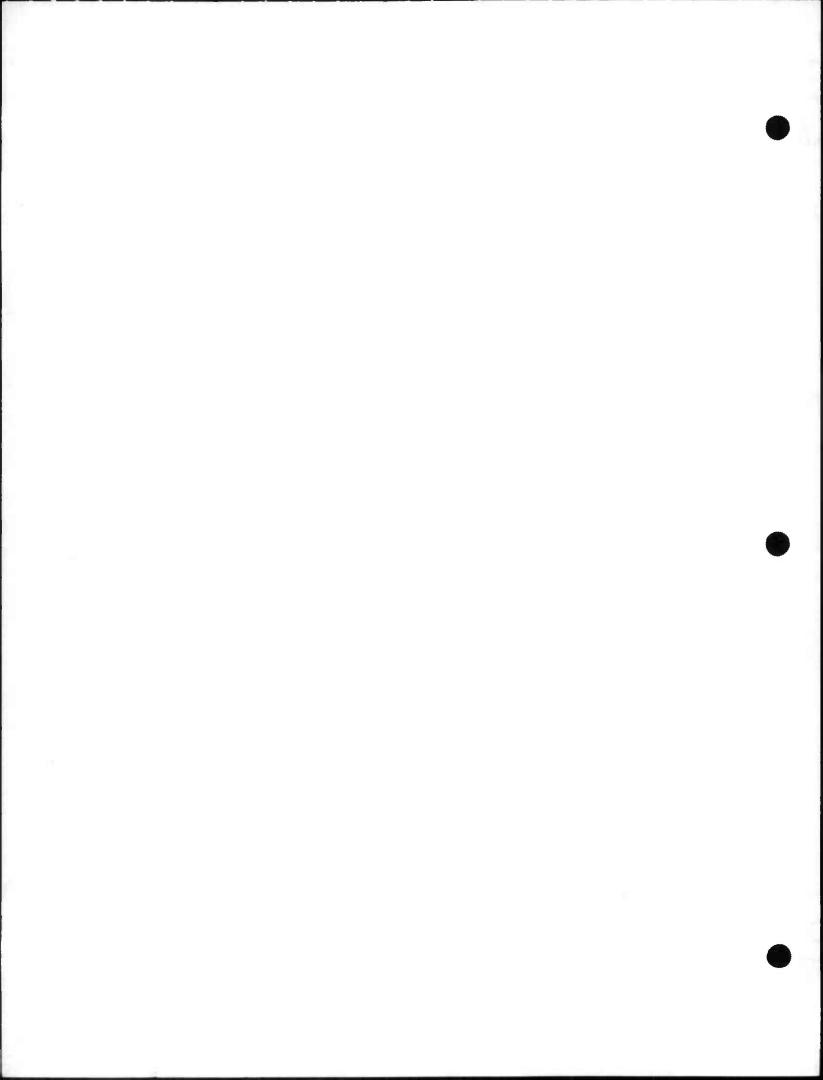
other traumatic

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nours after death. Page 6 may be retained by the hospital or attending physician.

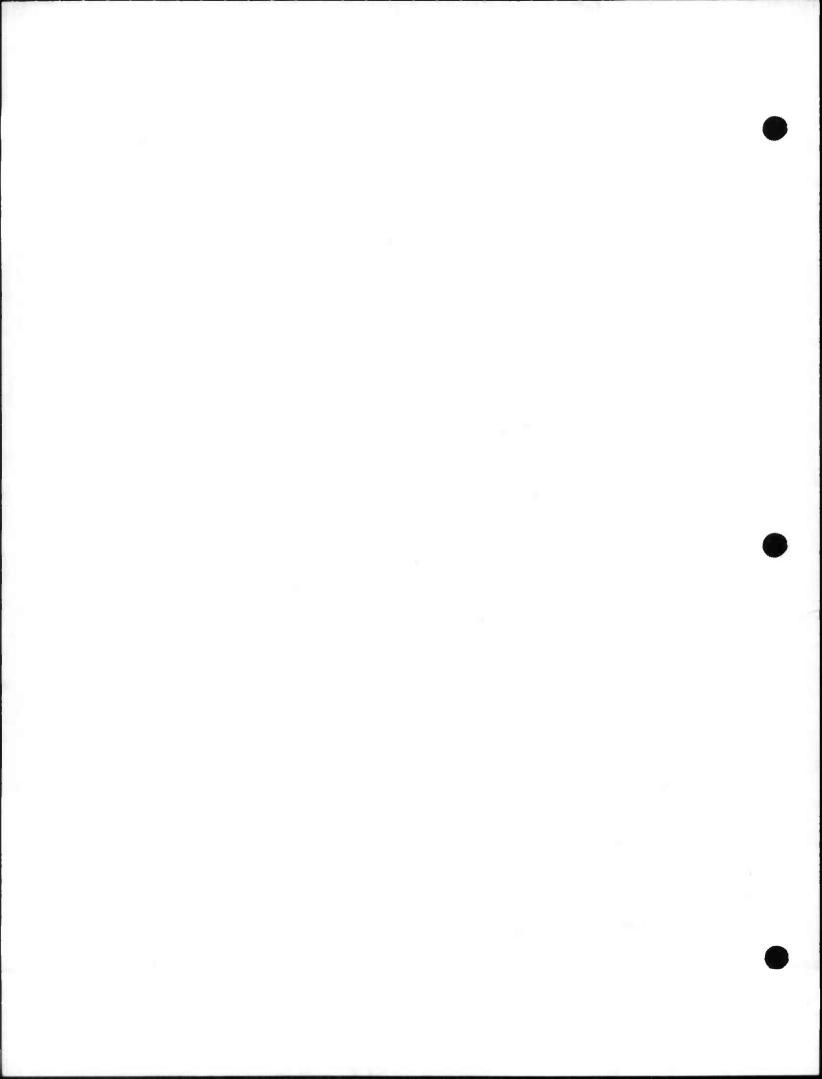
BALTIMORE, MARYLAND 21215-0020

CHEVY CHASE, MD. 20815



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		FOR 1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	RTMENT OF I	HEALTH AND I	MENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Migidio, Last)	1 1992	3. TIME OF DEATH						
Pir		4. SOCIAL SECURITY NUMBER 577-34-7113	1 🗆 M 2 💢 F	E (In yrs. lest birthday) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.			BIRTHPLACE (State or Foreign Country) laryland	
, 2, 3 should	стов	9a. FACILITY NAME (If not institution, give st SUBURBAN HOSPITA RESIDENCE OF DECEDENT	ŕ		Betheso	OR LOCATION OF DE	EATH	9c. COUNTY Monto	of DEATH JOMETY	
it. Pages 1,	DIREC	10e. STATE 10b. COUNTY	gomery		v, town on Loca lver Spi				10d. INSIDE CITY LIMITS? 1 YES 2 XXNO	
n. ansit permit.	FUNERAL	100. STREET AND NUMBER 2700 Barker Str	eet		10	f. ZIP CODE	0910		of WHAT COUNTRY? d States	
1215-0020 or attending physician. r use as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Midowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 1 YE IF YES, GIVE WAR OR	S 2 X NO	If yes, sp		IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	12.00	RACE — American Indian, Black, White, etc. Specify: White	
	PLETED	15. DECEDENT'S EDU((Specify only highest grade Elementary/Secondery (0-12)		(Give kind of life. Do NOT u	usual occupati work done during me se retired.)	ON ost of working	16b. KIND OF BU			
MARYLAND set retained by the hospital should be detached to rottlined at once.	BE COMPL	17. FATHER'S NAME (First, Middle, Last) (Unavailable) M	unday	TOINE	III A CEL		ME (First, Middle, Malder ilable			
60 40	TO 8	190. INFORMANT'S NAME (Type/Print) Carolynda Campbel 20a. METHOD OF DISPOSITION			Summer	Place,	Herndon,	VA 2207	1	
e 6 m ector,		1 Buriel 2 Cemetion 3 Remark 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	oval from State	Suburban	Cramato	DTY	3-19 Sil		ing, Maryland	
SAL r death ne fune al.		Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23. PART I. Enter the disease, or complications that deused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate								
24 hours filled in 1 ion, or re		shock, or heart feilure. I	List only one ceuse on	eech line.		cae or dying, auch	as cerdlec or resp	oiratory arrest,	Approximate interval Between Onset and Death	
be executed that and control to burial, aumatic en	ATION	Sequentially list conditions, if any, leading to immediate b. Congress of Reft log: DUE TO (OR AS A CONSEQUENCE OF):								
rth certificate tending physical Hyglene por other	ERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	OUE TO (OR AS	A CONSEQUENCE O	F):	<u>Cacelou</u>	X 000			
signed by the Health and M	MEDICAL C	PART II. Other significant conditions	s contributing to death	but not resulting	In the underlyin	g cause given in	Pert I. 24a. WAS AN PERFO	RMEO?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
The law te has b ate Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. P	LACE OF OEATH (Che	ock anly one)			
PHYSICIAN: The this certificate with the State intent or item	PHYSI	1 VES NO 27. MANNER OF DEATH 1 Natural 5 Pending	1 Inpatient 2 ER/Ou 28e. DATE OF INJUM (Month, Day, Year)	Y 28b. TIM	4 Nursing Hon E OF 28c. IN.	Ne 5 Residence	8 Other (Specify) 28d. OESCRIBE HOW	INJURY OCCURE	:0	
ATTENDING ECTOR: After sum death	TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJUR building, stc. (Sp	RY — At home, ferm, secify)		YES 2 NO office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
NO COLUMN	COMPLET		CIAN: To the best of my kno						use(s) e <i>nd m</i> enner es stated.	
	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Les	m		29c. LICENSE NUMBER 29d. DATE SIGNED (Month, De)				
~~000		30. NAME AND ADDRESS OF PERSON WHO 31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	ENATURE .	8218	s we	>Com SIL	A C	مو موا	
ļ		MAR 19 '93	Julia Davi	dson-Rondal	e				DHMH-16 Rev 1/89	



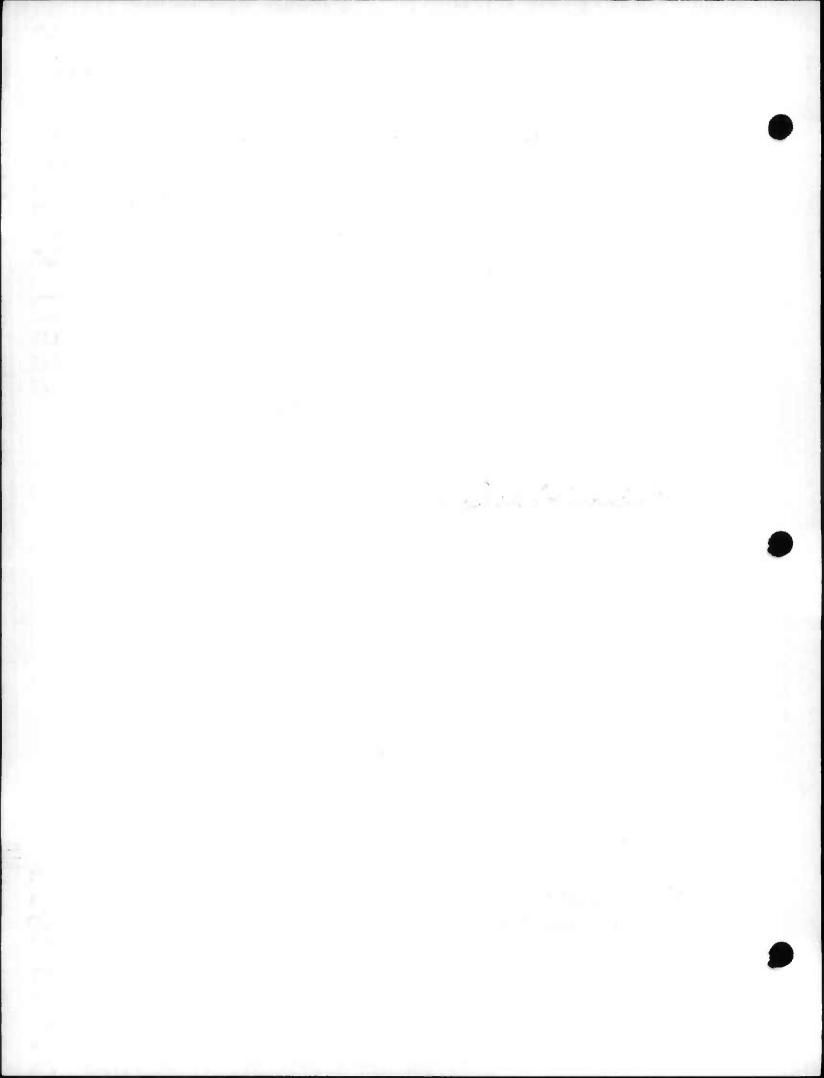
DIVISION OF VITAL RECORDS, P.O. BOX 13146,

DIVISION OF VITAL RECORDS, F.O. BOX 13149, TO THE HOSPIDU OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a work of each. Page 6 may be retained by the hospital or attending to THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be described for use as the filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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31. DATE FILED (Month, Day, Year)
MAR 19 93

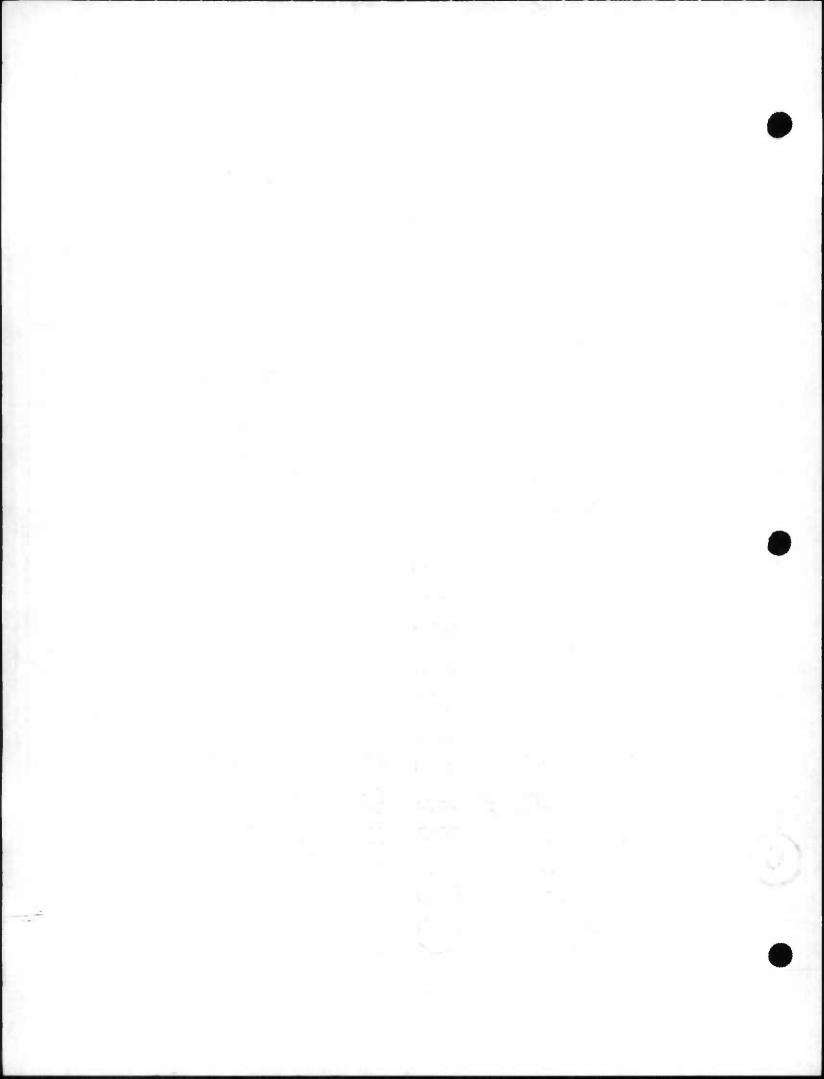
32. REGISTRAR'S SIGNA Lulia Davidson

								93	08776
FOR STATE REGISTRAR	STATE OF MARYL								
1. DECEDENT'S NAME (First, Middle, Lest)	Dorothy E		N			MONTH	ATH DAY	YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. last birthday,	IF UNDER MONTHS			7. DATE OF BIF (Month, Day,	Year)	B. BIRTHE	PLACE (State or Foreign
De FACILITY NAME (If not institution, give street of the s	eet and number)	ICC Valley Rd-Ros	96. CITY			EATH	9c. C0	DUNTY OF DE	
10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Washington,									10d. INSIDE CITY LIMITS? 1 X YES 2 NO
10. STREET AND NUMBER 3000 Tilden Stre	10f. ZIF	CODE		10g. C					
11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 X NO		if yes, specify	Cuban, Mexica	n, Puerto Rican,			- American Indian, White, etc.
		(Give kind o life, Do NOT	f work done (use retired.)	CCUPATION during most of	working				9
17. FATHER'S NAME (First, Middle, Last) Thomas A. Gorman	1			16		AME (First, Middle,	Maiden Sumame		
John P. Cole, Jr	•			100000000000000000000000000000000000000		-			6
4 Donation 8 Dother (Specify)	val from State	other place)	vet C	emete	ry	3/18			
21. SIGNATURE OF FUNERAL SERVICE LICE	Thelin	~	J	oseph	Gawler	r's Sons			n,DC 20016
	lst only one ceuse on e	ech line.			of dying, suc	ch as cardiac o	r respiratory	arrest,	Approximata Interval Between Onset and Death
disease or condition resulting in death)									1 Minula
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE	OF):	mlu	~ 40	sur			7eurs.
that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE	OF):						
PART II. Other algnificant conditions	contributing to death b	ut not reaulting	g in the ur	nderlying co	ause given in		PERFORMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp	patient 3 🗆 DOA		R:			olfy)		
27. MANNER OF DEATH 1 Netural 5 Pending Investigation	26a. DATE OF INJURY (Month, Day, Year)		IME OF	28c. INJURY WORK	AT			OCCURED	
3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	' — At home, fam clfy)	n, street, fac	tory, office		281. LOCATION City or Tow	(Street and Num n, State)	nber or Rural F	oute Number,
anal .				time, date and	d place, and du				
2 MEDICAL EXAMINER	CON the basis of axaminatio	n and/or investiga	ition, in my	opinion, deati	n occured at the	e time, date and p	elece, and due t	o the cause(s) and menner as stated.
	1. DECEDENT'S NAME (First, Middle, Last) 1. DECEDENT'S NAME (First, Middle, Last) 1. SOCIAL SECURITY NUMBER 1. SOCIAL SECURITY NUMBER 1. SOCIAL SECURITY NUMBER 1. SOCIAL SECURITY NUMBER 1. SOCIAL SECURITY NUMBER 1. SOCIAL SECURITY NUMBER 1. MARITAL STATE 1. Decedent of Decedent 1. MARITAL STATUS 1. Mever Married 1. MARITAL STATUS 1. Mever Married 1. Mever Married 1. SOCCEDENT'S EOUC (Specify only highest grade of Specify only highest gra	STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) DOTOTHY 4. SOCIAL SECURITY NUMBER 5. SEX 4. AGE (718-18-776-7 1 M 2 AF 9a. FACILITY NAME (If not institution, give street and number) 9a. FACILITY NAME (If not institution, give street and number) 10a. STATE 10b. COUNTY 10a. STATE 10b. COUNTY 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 12. WAS DECEDENT EVER IN FORCES? 1 VES IF YES, GIVE WAR OR DUST IN VES IF YES, GI	STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 1. DECEDENT'S NAME (First, Middle, Last) 1. DECEDENT'S NAME (First, Middle, Last) 1. MARITAL STATUS 1.	STATE REGISTRAR 1. DECEDENT'S NAME (First, Micdis, Lead) DOTOTHY E GOTMAN 4. SOCIAL SECURITY NUMBER 1. M 2 AF B WYS 96. FRACILITY NAME (if not institution, give strove and numbed) 96. FRACILITY NAME (if not institution, give strove and numbed) 96. CTY, TOWN Washin 106. CTY, TOWN Washin 107. STREET AND NUMBER 3000 Tilden Street, N. W. 11. MARITAL STATUS 15. Never Martied 15. Never Martied 15. Never Martied 16. DECEDENT'S SOLICATION (Specify only highest gradic compilend) Elementary/Secondary (9-12) College (1-4 or 5+) 108. MARLINO ADDRESS 1919 Penn 192. MFORMANT'S NAME (First, Micdis, Lead) Thomas A. Gotman 192. MFORMANT'S NAME (First, Micdis, Lead) Thomas A. Gotman 192. MFORMANT'S NAME (First, Micdis, Lead) Thomas A. Gotman 192. MFORMANT'S NAME (First, Micdis, Lead) Thomas A. Gotman 193. NFORMANT'S NAME (First, Micdis, Lead) Thomas A. Gotman 194. 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DUE TO (OR AS A CONSECUTENCE OF): 257. MANNER OF DEATH 1 (Michity, Day, Year) 258. DATE OF RAUHY 259. DATE OF RAUHY 259. DATE OF RAUHY	STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Land) A. SOCIAL SECURITY NUMBER 1. M 2 P S S NAME (First, Middle, Land) 1. M 3 P S S NAME (First, Middle, Land) 1. M 4 D Normal S Name (First, Middle, Land) 1. M 4 D Normal S Name (First, Middle, Land) 1. M 4 D Normal S Name (First, Middle, Land) 1. M 4 D Normal S Name (First, Middle, Land) 1. M 4 D Normal S Name (First, Middle, Land) 1. M 4 D Normal S Name (First, Middle, Land) 1. M 5 D Name (First, Middle, Land) 1. M 5 D Name (First, Middle, Land) 1. M 6 D Name (First, Middle, Land) 1. M 6 D Name (First, Middle, Land) 1. M 1 D Name (First, Middle, Land) 1. M 1 D Name (First, Middle, Land) 1. M 1 D Name (First, Middle, Land) 1. M 1 D Name (First, Middle, Land) 1. M 1 D Name (First, Middle, Land) 1. M 1 D Name (First, Middle, Land) 1. M 1 D Name (First, Middle, Land) 1. 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DECEDENT'S NAME (First, Modes, Last) A SOCIAL SECURITY MAME (First, Modes, Last) A SOCIAL SECURITY MAME (First, Modes, Last) A SOCIAL SECURITY MAME (First, Modes, Last) A SOCIAL SECURITY MAME (First, Modes, Last) A SOCIAL SECURITY MAME (First, Modes, Last) A SOCIAL SECURITY MAME (First, Modes, Last) A SOCIAL SECURITY MAME (First, Modes, Last) A SOCIAL SECURITY MAME (First, Modes, Last) A SOCIAL SECURITY MAME (First, Modes, Last) A SOCIAL SECURITY MAME (First, Modes, Last) THE SIGNATURE OF DECEDENT SOCIAL STATE SOCI	STALE THAN THE CONTROL OF DEATH STATE AND MANUAL (First, Model, Land) 1. DECEDITY MANUAL (First, Model, Land) 1. DECEDITY MANUAL (First, Model, Land) 1. DECEDITY MANUAL (First, Model, Land) 1. DECEDITY MANUAL (First, Model, Land) 1. DECEDITY MANUAL (First, Model, Land) 1. DECEDITY MANUAL (First, Model, Land) 1. MANUAL STATE 1. MANUAL ST	SALE SCHOLLY MANUE (PILL MOSS). LEID DOTOLTH E GOTTERN PLANE (PILL MOSS). LEID DOTOLTH E GOTTOLTH E GOTTERN PLANE (PILL MOSS). LEID DOTOLTH E GOTTERN PLANE



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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND
TO THE HIGHERIAL OF ATTENDIANS PHYSICIAN: The law requires that the death certificate be executed within 24 flours after death. Page 6 may be retained by the hosp
TO THE WARRY PROPERTY AND THE CONTINUES HAS BEEN SIGNED BY the attending physician and completely filled in by the funeral director, page 5 should be detached
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR	OTATE OF I	MADVIAND / D	OADTIALL:	. 05 1	ICALTII	AND	AFNITAL	LIVOITNI		U	0111
	- STATE REGISTRAR	SIAIE UF I	MARYLAND / DE Cer	TIFICATI				MENIAL	REG. NO.	<u> </u>		
	1. DECEDENT'S NAME (First, Middle, Last) Anne G. Gadzuk							2. DATE O MONTH Marc		, 1993	YEAR	5:00 A. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest birt	thday) IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE O				PLACE (State or Foreign
	016-38-9134	1 M 2 X F	84	YRS.				Nov	. 12,	1908		PA.
~	9a. FACILITY NAME (If not institution, give st			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								
6	Potomac Valley Nu	rsing Ce	nter	Rockville Mc				Mont	lontgomery			
DIRECTOR	10a. STATE 10b. COUNTY		10	DC. CITY, TOWN	OR LOCAT	TION						10d. INSIDE CITY LIMITS?
		tgomery		Poton	-							1 YES 2 NO
FUNERAL	104. STREET AND NUMBER 10411 Great Arb	on Duisso			101	. ZIP COD	≖ 20854	,		10g. CITI2	U.S	A A
NE I	11. MARITAL STATUS	12. WAS DECEDE	NT EVER IN U.S. ARMED			ENDENT (OF HISPAN	NIC ORIGIN?	(Specify Yes	or No-	14. RACE	- American Indian.
	1 Never Married 2 Married		I ☐ YES 2 ☑ NO WAR OR DATES			ecity Cubi		in, Puerto Ri y:	can, etc.)		Specif	*
D BY	3 Widowed 4 Divorced				2012	•••		405	KIND OF BUS	1	1107771	White
	15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5	(Give i	DENT'S USUAL O dnd of work done NOT use retired.)	during me	ost of world	ng	160.	KIND OF BUS	SINESS/IND	USTRY	
7	Elementary/Secondary (0-12)	4	'	istered	Nu	rse			Nui	sing		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOT	HER'S NA	ME (First, M	iddie, Maiden	Sumame)		
BE (John Ya	cos							len I			
2	19a. INFORMANT'S NAME (Type/Print)	le		AILING ADDRES								954
	J. William Gadz	20b. PLACE AN	D DATE OF DISI	1 Great Arbor Drive, Potomac, MD. 20854 DATE of DISPOSITION (Name DATE 20c. LOCATION — City of Town, State								
1	1 Deurial 2 Cremetion 3 Removal from State of cemetary, cre 4 Donation 5 Other (Specify) Metrop				Crei	nato	cy	3/18	8 A1	exand	ria,	VA.
	-21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	7 , 1	22.	NAME A	ND ADDRE	SS OF FA	CILITY	DeVol	Fune	ra1	Home
	Michae	617-6	ulilia	ار اد) E.1	Deer	Park	k Dr.	, Gai	thers	burg	,MD. 20877
	23. PART I. Enter the diseases, or shock, or heert fellure.			. Do not ente	r the mo	ode of dy	ing, auc	ch aa cerdi	lec or resp	ratory arr	eat,	Approximate Interval Between
	IMMEDIATE CAUSE (Finel disease or condition											Onset and Deeth
	resulting in deeth)		neumonia	NCE OF:								3 Days
_			lzheimer's									Years
CERTIFICATION	Sequentially liet conditions, if eny, leeding to immediate	DUE TO	O (OR AS A CONSEQUE	NCE OF):								
-ICA	CAUSE (Disease or Injury	c	O (OR AS A CONSEQUE	NCE OF:								-
RTI	that initieted events resulting in death) LAST	200.0	(0117107100102002									
. 1	PART II Other significant condition	a contributing t	o death but not rea	ulting in the u	ndedyla	C COLICA	aluan In	Part I	24a, WAS AN	ALITTOPEV	245	WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL	PART II. Other significent condition	e contributing t	o deeth bot not reed	arting in the d	ilderiyii	g ceuse	given in	Part I.	PERFO	RMED?	240	AVAILABLE PRIOR TO COMPLETION OF CAUSE
EDI								_	1 TYES	NO		OF DEATH? 1 YES 2 NO
2												
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHE	_	LACE OF	DEATH (C)	heck only one	9)			
YSI	1 WES 2 NO	1 Inpatient 2	☐ ER/Outpatient 3 ☐		irsing Hor		tesidence	6 🗆 Other				
	27. MANNER OF DEATH 1 Natural 5 Pending	26e. DATE C (Month,	Day, Year)	16b. TIME OF INJURY	W	JURY AT ORK? YES 2	□ NO	26d. DE\$	CRIBE HOW	INJURY OC	CURED	
ВУ	2 Accident Investigation 3 Suicide 6 Could not be		OF INJURY — At home	, ferm, street, fe				261. LOCA	ATION (Street	and Number	or Rural I	Route Number,
COMPLETED	3 Suicide 6 Could not be 4 Homicide determined	building	g, etc. (Specify)					City o	or Town, State)		
PLE	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best	of my knowledge, death	occurred at the	time, dat	e and plec	e, and du	a to the cau	ee(a) and ma	nner aa sta	ted.	
MO	000	ER: On the basis of	examination and/or inve	estigation, in my	opinion,	death occ	ured at the	e time, date	and place, a	nd due to th	he cause(i	s) and manner as stated.
ш	296. SIGNATURE AND TITLE OF CENTRE	R X	1000	_		29c. Li	CENSE NU	MBER				(Month, Day, Ybar)
10 B	30, NAME AND ADDRESS OF PERSON WI	S COMBI STEP S	COT S	7 Page 25-1		D	213	92		M	larch	17, 1993
	Patricia D. Kel		1		11 R	d	Rock	ville	, MD	2085	1	
	31, DATE FILED (Month, Day, Year)	32. REGISTI	RAR'S SIGNATURE			,			,			
	MAR 19 '93	gul	ia Davidson A	andell								

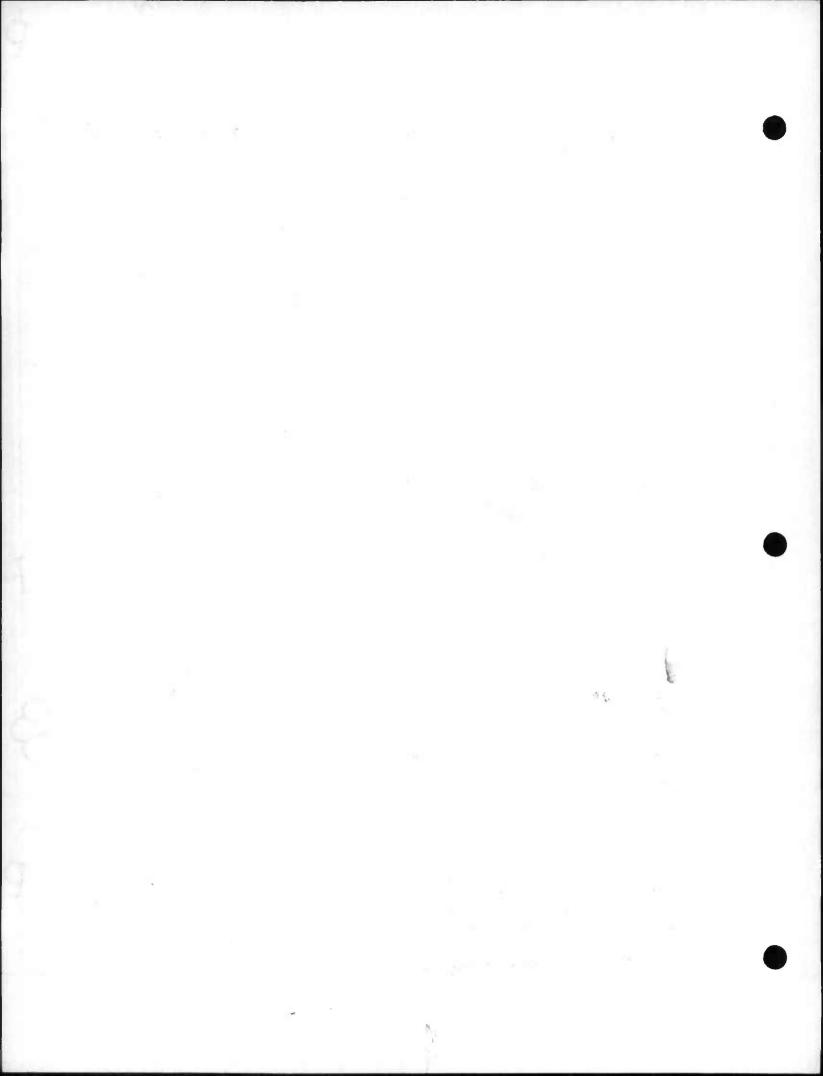


STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3-(1 reen YEAR Leroy 4. SOCIAL SECURITY NUMBER 238-14-9504 April 6,1921 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 71 YRS. South Carolina HOURS 1 M 2 | F page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Prince George's Hospital Ctr. DIRECTOR Cheverly Prince George's RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Washington, D.C. 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 20019 5361 Ames St. N.E. U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Mexican, Puerto Ricae, etc.)
 \(\sum_{YES} \) NO \(Specify: \) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify: Black BY 3 X Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 8th grade Truck Driver Ellis Construction Co. notified at once. 17. FATHER'S NAME (First, Middle, Last)
John Green 18. MOTHER'S NAME (First, Middle, Maiden Surname) Viola Johnson BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 3530 Edwards St. Landover, Maryland 20785 Bertha M. Hudson (Niece) 99 20a. METHOD OF DISPOSITION
1 Burlet 2 Cremation 3 Re
4 Donation 5 Other (Specify) DATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must director, Harmony Memorial Park 3/6/93 Landover, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENS 22. Ravelabinous of turneral Home, Inc. the funeral 4339 Hunt Place, N.E. Wash. D.C.20019 medical 23. PART I. Enter the diseases, or complications that caused the deshock, or heart failure. List only one cause on each line. and completely filled in by burial, cremation, or remo one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between IMMEDIATE CAUSE (Final Onset and Death traumatic event, the Emoschette aa skid vaseuler dieuse disease or condition DOCPITAL OR ATTENDING PRESIDENT The law requires that the death certificate be executed within resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): the attending physician a Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events other DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 10 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? signed by the 23 shows any 1 TYES 2 TLNO OF DEATH? 1 TYES 2 NO certificate has been PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER2 HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 TES 2 NO e 5 🗆 Residence 8 🗆 Other (Specify) 4 🗌 Nu 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 朝 28b. TIME OF 28d, DESCRIBE HOW INJURY OCCURED marked. 1 Natural 5 Pending Investigation 1 YES 2 NO BY After 2 Accident 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined FUNERAL DIRECTOR: AIThin 72 hours after COMPLETED 4 Homicide 28 Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated 2 MEDICAL EXAMINER: On the basis of examination and/or within To the Tay BE 30 2 2

32. REGISTRAR'S SIGNATURE

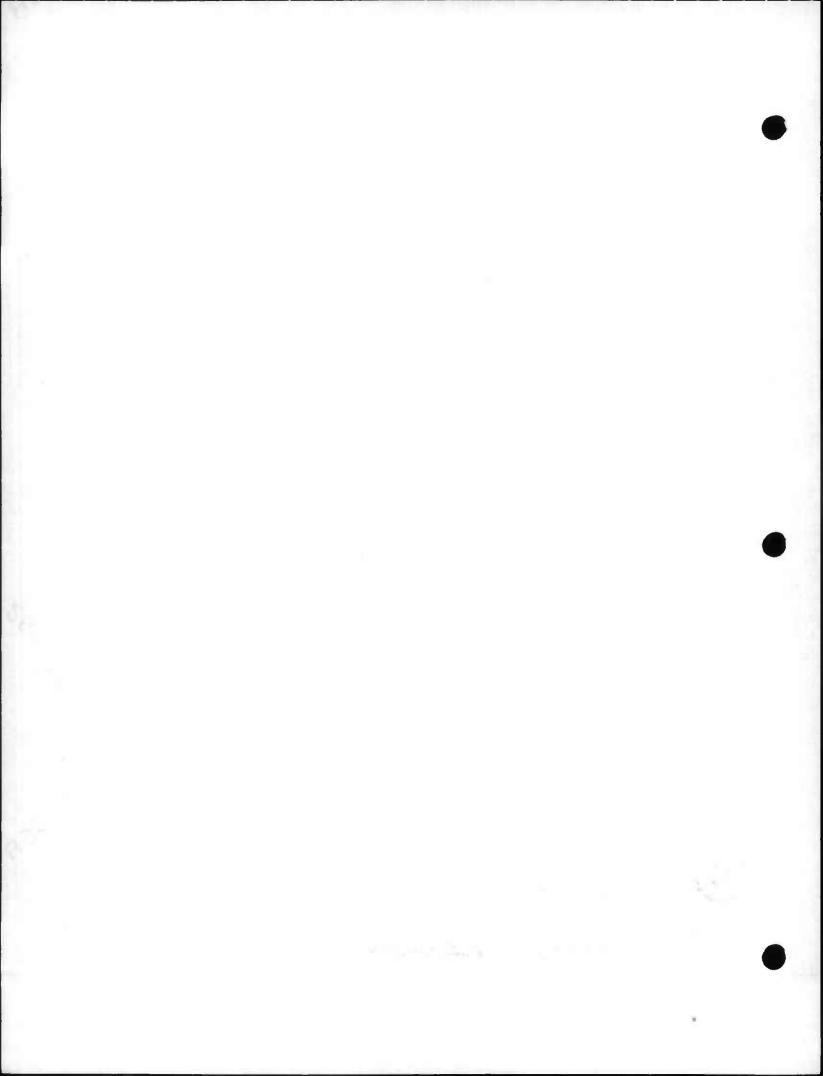
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BALTIMORE, MARYLAND 21215-0020	TINDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	FAL DRECIDE. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be made and the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	I file marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	cate be executed within	TRAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral AZ hours arm death with the State Dept, of Health and Mental Hydiene prior to burial, cremation, or removal.	er traumatic event,
3DS, P.O.	it the death certifi	by the attending p	Injury, or oth
- RECOF	aw requires tha	s been signed apt. of Health a	3 shows any
F VITAI	SICIAN: The I	certificate ha	I, or Item 2
O NOIS	NOING PHYS	R: After this in death with	is marked
DIVIS	AL OR ATTE	AL DIRECTO	If them 28
	5	15.00	-21

	FOR STATE REGISTRAR	STATE OF MAR			TMENT 0			MENTAL		93	08779	
3	1. DECEDENT'S NAME (First, Middle, Last)	F. G1.	o de		Sr	JF DE	AITI	2. DATE O	REG. NO.		YEAR 3. TIME OF DEATH	м
	4. SOCIAL SECURITY NUMBER 579-26-0412	1 🖾 M 2 🗌 F	NGE (In yrs. las	t birthday) YRS.		WS HOU		7. DATE 0 (Month, 10/			BIRTHPLACE (State or Foreign Country) Lson Co., Va	
10R	Prince George RESIDENCE OF DECEDENT		al Ce	nte:		ww or Loc heve	rly	EATH			ce George's	
DIRECTOR	10e. STATE Md . 10b. COUNTY	P.G.		10c. CIT	Y, TOWN OR L						10d. INSIDE CITY LIMITS? 1 [X] YES 2 [NO	
FUNERAL	100. STREET AND NUMBER 7752 Burnsi	de Rd.		-		101. ZIP C	0785				EN OF WHAT COUNTRY?	
₩	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR C	YES 2XX		If ye	OECENDER	NT OF HISPAN Cuban, Mexica NO Spec/f)	n, Puerto R	(Specify Yes lcan, etc.)		14. RACE — American Indian, Black, White, etc. Specify: Black	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 8th	CATION completed) College (1-4 or 5+)	(Gilfe.	CEDENT'S ive kind of a Do NOT us	USUAL OCCU work done during ee retired.)	PATION og most of w	orking	I	Brent			
BE CO	17. FATHER'S NAME (First, Middle, Last) Faggie Glov	er						cia I	Keys			
2	196. INFORMANT'S NAME (Type/Print) Corese S. Glove	r		Same	ADDRESS (SI	# 10		7e				
	20e. METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Remote 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE		cametery, cre	matory or o	coln	Cem.					od, Md.	
	· Sarry,	A. Pr	att		49	.S.W.	ashir urrou	igtor ighs	Ave.	, N.E	•	
	23. PART I. Enter the diseases, or of shock, or heert failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one couse of	on each line	he	lande						Onset and Dear	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	C	AS A CONSEC									
PHYSICIAN: MEDICAL C	PART II. Other algorificent condition	a contributing to dea	th but not r	esulting	in the under	lying caus	se given in	Part I.	24a. WAS AN PERFOR 1 YES 2	IMED?	24b. WERE AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	s
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMMER? 1 YES 2 NO	HOSPITAL:	Outpatient 3	□ DOA	OTHER:		F DEATH (Chi		-			\exists
ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJU (Month, Day, Ye	IRY	28b. TIM	E OF 280	WORK?	r			NJURY OCCU	JRED	
APLETED B	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJ building, stc. (IURY — At ho (Specify)	me, farm, s	street, factory,	office		281. LOCA City o	TION (Street a Town, State)	and Number o	er Rural Route Number,	
OMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC ONE) 2 MEDICAL EXAMINE										d. cause(s) and menner as stated.	
WW)	296. SIGNATURE AND TITLE OF CERTIFIER	Congre	M	N		290	DICENSE NUM	BER 30)	29d. DATE ▶ 3	SIGNED (Month, Day, Veer)	
T_	Andre P Rac	wowar	MP	1 27) (Type,	Print)	Pays.	nem	OP.	Cos	m.//	1820748	-
	MAR 1 2 19	32. REGISTRAR'S S	SIGNATURE	n- Par	pless							



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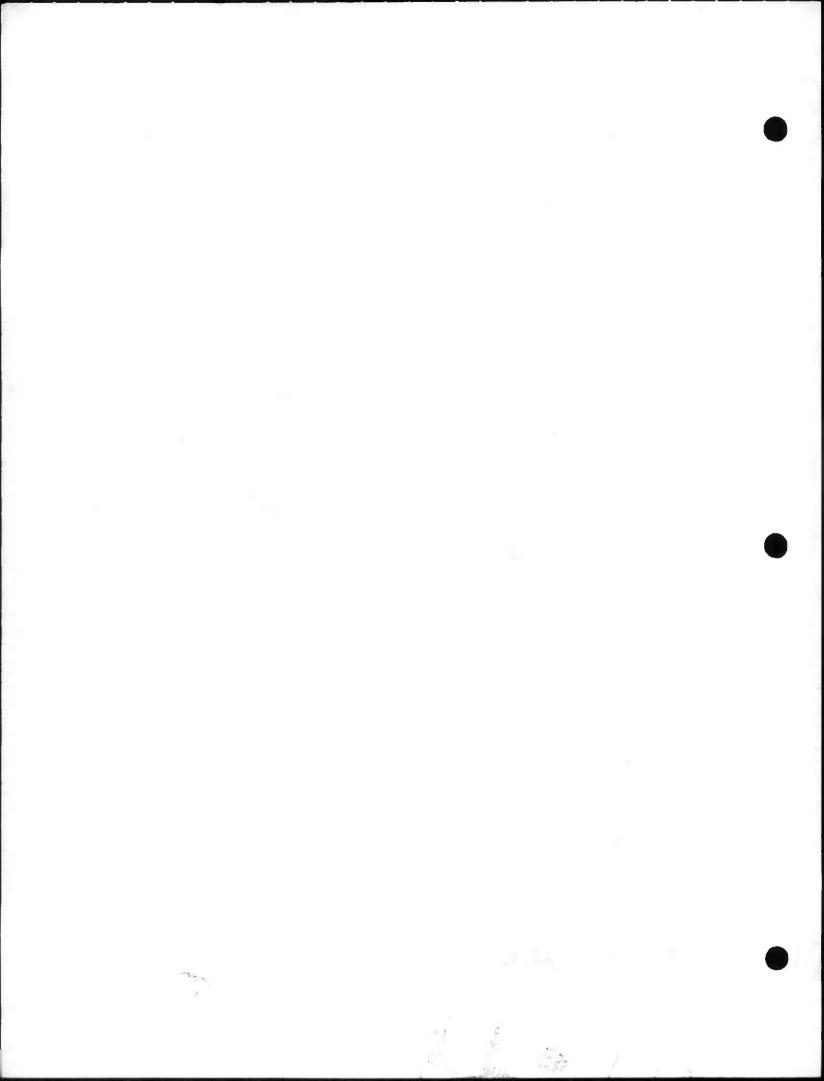
THE HOPPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO HE PLACEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the process of the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE	0F	MARYLAND	/ DEPARTMENT	OF	HEALTH	AND	MENTAL	HYGI	ENE
		C	ERTIFICATE	OF	DEA1	TH		REG.	NO.

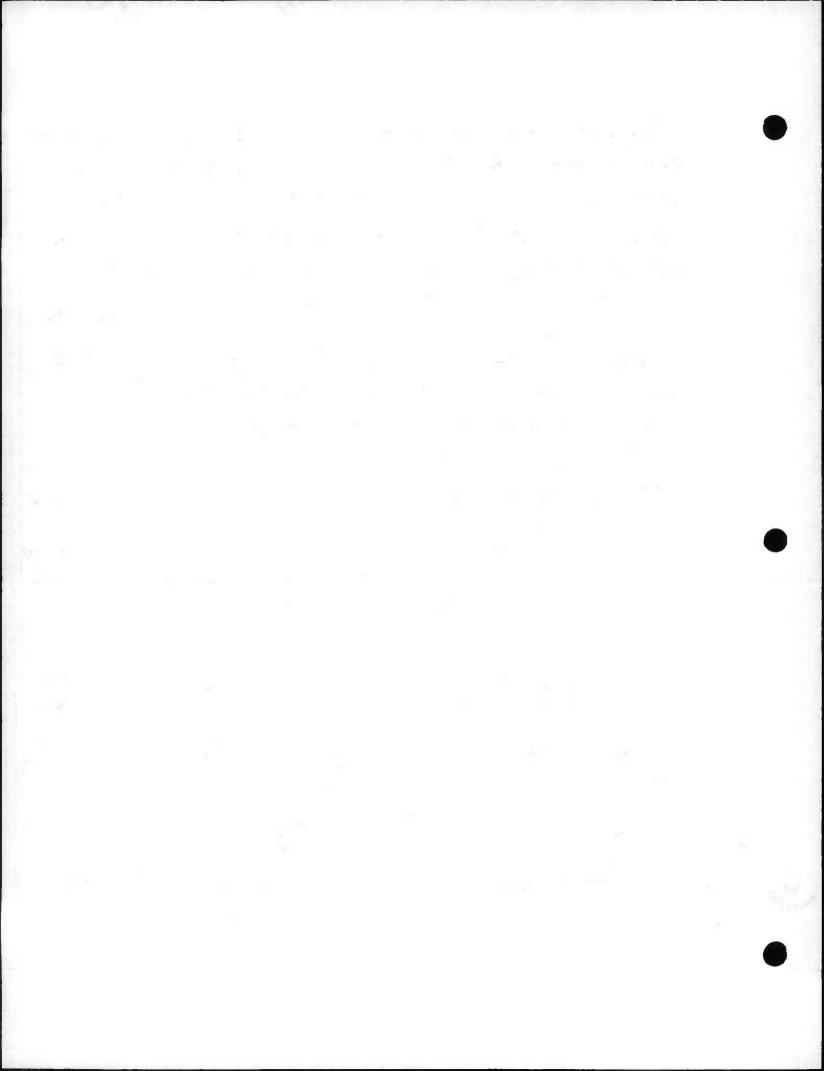
	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPART			MENTAL HYGI			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	Н	YEAR 3	. TIME OF DEATH
	Geoffrey 4. SOCIAL SECURITY NUMBER	Worcester Gre				March	6 199:	3	12:20 P M
		5. SEX 6. AGE (In y)		ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yea	r)	Country)	ACE (State or Foreign
	475 74 7154 9e. FACILITY NAME (If not institution, give			DE CITY, TOWN O	R LOCATION OF I	June 9	1964 sc. COUNT	Ohio	
OR	1907 Topango Pla			Croft			11.00		ındel
ECT	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	ry	Mo CITY	TOWN OR LOCAT					
DIRECTOR	Maryland Ann	e Arundel		Crofton	ION				Od. INSIDE CITY LIMITS? YES 2 1 40
	10e. STREET AND NUMBER				ZIP CODE		10g. CITIZE		AT COUNTRY?
FUNERAL	1907 Topango Pla				21114		Uni	ited	States
	11. MARITAL STATUS 12 Never Merried 2 Merried	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2	. ₽ NO	If yes, spe	cify Cuben, Mexic	ANIC ORIGIN? (Specify can, Puerlo Rican, etc.		4. RACE - Black, V	- Americen Indien, White, atc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	No	1 TYES	2 NO Spec	No.		Specify:	White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grad	JCATION 16 e completed)	a. DECEDENT'S US	SUAL OCCUPATION done during mos			BUSINESS/INDU	STRY	MILLE
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use i	retired.)	it or working				
MP.	12 17. FATHER'S NAME (First, Middle, Last)		Chief		40. 1407147010 14	Res	taurant	Rus	iness
	Normand W. Green					M. Thrawl			
TO BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AI	DDRESS (Street at	nd Number or Rura	I Route Number, City or	Town, State, Zip C	Code)	
F	Deborah L. Balzar	rini	10 Re	d Oak D	rive L	incoln Un	iversit	v Pa	19352
	20a. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☑ Çremation 3 ☐ Ran	noval from State cemeter	ACE AND DATE OF	DISPOSITION (Nat	me of	DATE 20c	LOCATION — CH	ty or Town	, State
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI		tropoli		matory D ADDRESS OF F	ACHITY	Alexan	dria	Virginia
	Polist &	Em. I	200	Beal	1-Evans	Funeral			
	23. PART i. Enter the diseases, or	complications that canad th	a death Do not	1600	O Annap	olis Rd.	Bowie M	d. 20	
	ahock, or haart fallura.	List only one cause on each	iina.	t anter the mot	ie of dying, su	on as cardiac of re	eapiratory arres	it,	Approximate interval Batween
	disease or condition resulting in deeth)	AIDS							Onset end Death
	reauting in deeth)	DUE TO (OR AS A CO	NSEOUENCE OF):						7773
NO	Sequentially list conditions,	b							
ATI	if any, leeding to immediata cause. Entar UNDERLYING	DUE TO (OR AS A CO	NSEQUENCE OF):						
FI	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	NSEQUENCE OF):						
CERTIFICATION	resulting in death) LAST	d							
AL C	PART ii. Other significant condition	na contributing to deeth but i	not resulting in	tha underlying	cause givan ir	Part i. 24a. WAS	AN AUTOPSY		ERE AUTOPSY FINDINGS
20							FORMED? B 2 NO	l co	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
ME							- (/		YES 2 NO
Ä									
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	C	THER:	ACE OF DEATH (C				
H	27. MANNER OF DEATH	1 Inpatient 2 ER/Outpatien 28e. DATE OF INJURY	28b. TIME C	OF 28c. INJU		a Other (Specify)	W INJURY OCCU	RED.	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	Y WOI	RK? ES 2 NO				
	3 Suicide a Could not be	28e. PLACE OF INJURY — ibuilding, etc. (Specify)	At home, farm, stre	et, factory, office		281. LOCATION (Str. City or Town, St	eet and Number or	Rural Roul	te Number,
	4 Homicide determined					Guy Gr Iomii, G	-		
COMPLETED	29e. CERTIFIER (Check only one)	ICIAN: To the best of my knowledg	e, death occurred	at the time, date	end place, end du	e to the ceuse(e) and	menner as stated		
8	2 MEDICAL EXAMINE	ER: On the basis of examination an	d/or investigation,	In my opinion, de	eath occured at the	e time, date and place	, and due to the	ceuse(e) ar	nd menner ee stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIE		D		29c. LICENSE NU	INBER	29d. DATE S	SIGNED (M	ontili, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE OF DEATH	(ITEM 27) (Type, Pr	rint)	99	1010	1 3	/ /	//3
	01 1 1	ns, 180 Adn		chrane	Drive	Annapolis	MQ.	21	401
	MAR 0 9 1993	32. REGISTRAR'S SIGNATUR	RE			1			



BALTIMORE, MARYLAND	hours after death. Page 6 may be retained by the hosp	od in by the funeral director, page 5 should be detached or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

08781 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 3

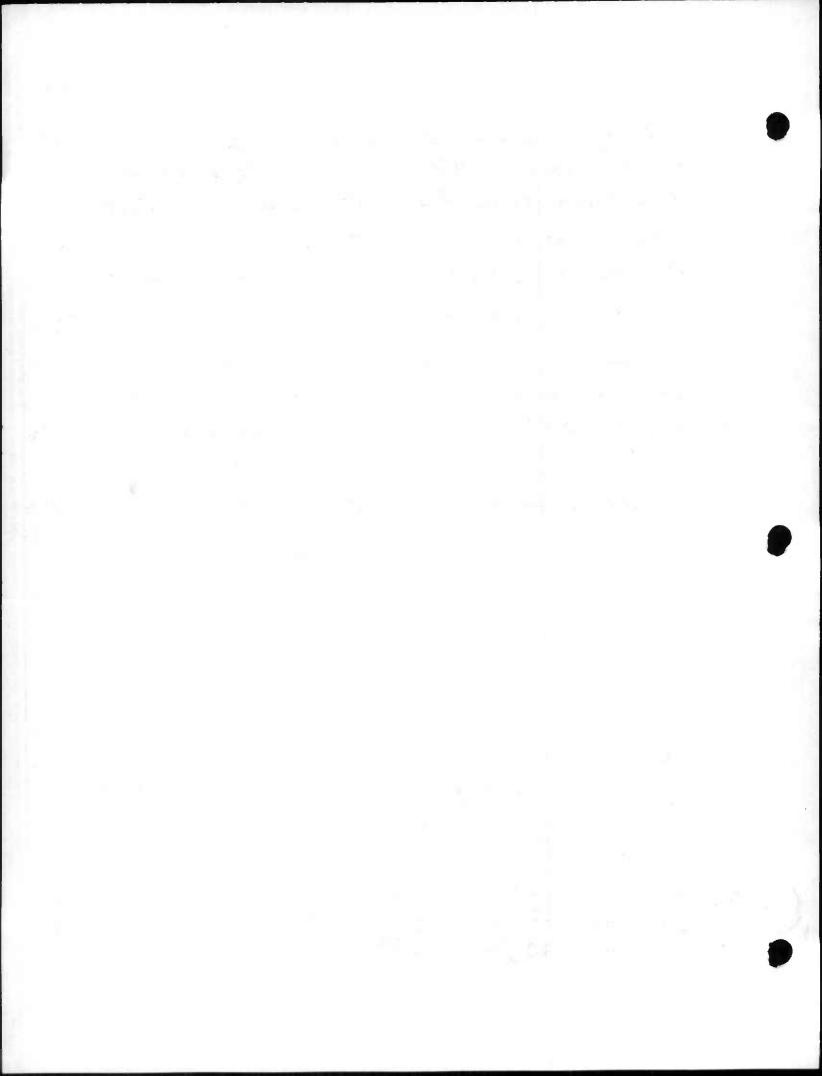
	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTM CERTIFIC	MENT OF HEALTH AND I	MENTAL HYGIENE 3	18180
	1. DECEDENT'S NAME (First, Middle, Last)	AYE GREUNICH		2. DATE OF DEATH MONTH DAY	3. TIME OF DEATH
			UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	B. BIRTHPLACE (State or Foreign
9	550-24-30%	1 □ M 2 XF 72 YRS. MO	NITHS DAYS HOURS MIN.	(Month, Dey, Year)	Country) CA
ron	9a. FACILITY NAME (If not institution, give stre	et and number) 91	ANNAPOL	EATH 9c. COUNT	A A
DIRECTOR	RÉSIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c. CITY, T	TOWN OR LOCATION	1/	10d, INSIDE CITY
	MD	A.A. St	everna Pa	rK	1 YES 2 NO
FUNERAL	137 ST. And	reus Road	101. ZIP CODE	6 10g. CITIZ	EN OF WHAT COUNTRY?
N N	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO	13. WAS DECENDENT OF HISPAN If yes, specify Cuben, Mexica	IIC ORIGIN? (Specify Yes or No-	14. RACE — American Indian, Black, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	1 TES 2 NO Specify		spectly white
TED	15. DECEDENT'S EDUCA (Specify only highest grade of	ompleted) (Give kind of work	done during most of working	16b. KINO OF BUSINESS/INDU	STRY
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	digist	FAMILY	Practice
OM	17, FATHER'S NAME (First, Middle, Last)			ME (First, Middle, Melden Surname)	
BE (00 1	t. COLLEASUR	E Bett	y Hazlil	
5	Dr. Richard C.	Greetich SAV		Poute Number, City or Town, State, Zip (Code)
	20s. METHOD OF DISPOSITION 1 Durial 2 SCremation 3 Remov	20b. PLACE AND DATE OF Commellers, cremetory of other		DATE 20c. LOCATION - C	24
	4 Donation 5 Other (Specify)	Wells Cre	EMAGORA 371	93 Catonsu	II e, MO
	Hobert S	h	BARRANCO SI	EVERNA PARK	PUNEKAL HAME
	23. PART I. Enter the diseases, or co	emplications that caused the death. Do not list only one cause on each line.			st, Approximate
	IMMEDIATE CAUSE (Final disease or condition	A comy one cause on each mie,			Interval Between Onset and Death
	resulting in death)	DUE TO (DR AS A CONSEQUENCE OF):			IMMEDIATE
z		METASTATIC C	ARCIWOMA N	A BREAST	YRS
일	Sequentisity list conditions, if any, leeding to immediate	DUE TO (OR AS A CONSEQUENCE OF):			
일	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSEQUENCE OF):			
CERTIFICATION	resulting in death) LAST				
	PART II. Other significant conditions	contributing to death but not resulting in t	he underlying cause given in	Part I. 24s. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
ICAL	DEME		, , , , , , , , , , , , , , , , , , , ,	PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	DEST	UEN THROBORALIO	Rins	INJUST IN	OF DEATH?
PHYSICIAN:			26. PLACE OF DEATH (Chi THER:		
нүѕ	1 VES 2 NO 27. MANNER OF DEATH	28e. DATE OF INJURY 28b. TIME O	Nursing Home 5 Residence F 28c. INJURY AT	6 Other (Specify) 28d. DESCRIBE HOW INJURY OCCU	JRED
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) INJURY	WORK? M 1 YES 2 NO		
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At home, farm, stree building, etc. (Specify)	it, factory, office	281. LOCATION (Street and Number of City or Town, State)	r Rural Route Number,
COMPLETED		IAN: To the best of my knowledge, death occurred a : On the basis of examination and/or investigation, i			
	29b. SIGNATURE AND WILL OF CENTIFIER	On the state of statement street investigation, i	29c. LICENSE NUN		
BE	Veter	Ware und	N	364 ≥ 3	SIGNED (Month, Day, Year)
10	0 0	COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Pri	int)		10000
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	BESTOATE R	0 #300 ANN	MYOLIS MIL
	MAR 1 8 199	3 Juna Davidson-Monarda			



examin
medical
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event,
NT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examin
other
6
Injury.
any
shows
23
Item
5
marked,
22
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATN		3. TIME OF DEATN
	GROVOR DAVIA O	SIFE ~	1.	MONTH DA	YEAR	11.70
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In vrs. I	JI K TO VE		D 8	93	1628 M
	Control of the second of the s	MONTHS DAY		7. DATE OF BIRTH (Month, Pay, Year)	8. BIRT Coun	NPLACE (State or Foreign try)
	471-70-8260 10 M2 OF 47	YRS.		7/16/4	15 I	NDIANA
_	9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOW	N OR LOCATION OF DEAT	TN	9c. COUNTY OF	DEATN
DIRECTOR	455 Shore Acres Ro	\mathcal{A}	rnold		A	1
ا 5	RESIDENCE OF DECEDENT	7/	14010		- tel	7
۱ پ	10a, STATE 10b. COUNTY	10c. CITY, TOWN OR LO	CATION	_		10d. INSIDE CITY
ā	MD. A.A	1+1	RNIOLL	\mathcal{O}		LIMITS?
ا دِ	10e. STREET AND NUMBER		101. ZIP COOE		40- CITIZEN OF	WHAT COUNTRY?
	455 Shore Heres RN Ap	121	2/10	()	log. CITIZEN OF	WHAI COUNTRY?
ž		27	2/0/	d	05,	/+
FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Married FORCES? 1 S YES 2		DECENDENT OF HISPANIC specify Cuben, Maxican,	ORIGIN? (Specify Yee	or No — 14. RAC	E — American Indian, ik, White, etc.
B	3 Wildowed A M Dhoward IF YES, GIVE WAR OR DATES	101	ES 2 NO Specify:	· derito rindari, etc.)	Spec	
- 1	1 1/1/10/51	/				white
LED	(Specify only nighest grade completed)	DECEDENT'S USUAL OCCUP.	ATION most of wadding	16b. KIND OF BUS	NESS/INDUSTRY	
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+)	fe. Do NOT use retired.)		110	4 . 4 .	V
<u> </u>	12	VAUY PIL	.OT	0.5.	NAV	7
5	17. FATHER'S NAME (First, Middle, Last)		10 MOTNER'S NAME	E (First, Middle, Maiden S		
	WILLIAM GIFFORD, J.	R	RUT	74 50	10CK	
H			1/201	11 011	10-1-	
2	WILLIAM OFFERD, JR.	9b. MAILING ADDRESS (Stre	et end Number or Rural Rou	ute Number, City or Town.	State, Zip Code)	1- 200
		Herring	U-VII LAN	14. HITO	in Head,	JC 29906
	1 U Buriel 2 DACremetion 3 U Removal from State compton of	E AND DATE OF DISPOSITION remetory or other place)	(Name of	OATE 20c. LOC	ATION — City or To	own, State
	4 Donation 5 Other (Specify)	n Creman	RY 3-10-	93 Cat	Sustille	, mo
Ì	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		AND ADDRESS OF FACIL	JTY		
	· Milost D	1 000		0	. —	0.44
	(I Aleas)	1 BAK	RANCO SE	evernall	METU	reralHame
- 1	23. PART I. Enter the diseases, or complications that caused the shock, or heart feliure. List only one cause on each lin	eeth. Do not enter the	mode of dying, auch o	es cerdiec or reepir	story erreet,	Approximete
	IMMEDIATE CAUSE (Fine)					Onset and Death
	disease or condition	1-1-	PAd.			Ollegt Blid Death
	resulting in death) a. DUE TO (OR AS A CONSE		,, <u>U</u>			
. 1		2002.102 01 /.				i 1
ALICI	Sequentielly list conditions, b.	FOURTH OF				
		EUDENCE OF):				
ā	if eny, leeding to immediate					i
ZA	cause. Enter UNDERLYING CAUSE (Disease or Injury					
IIIICAI	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events OUE TO (OR AS A CONSE	EOUENCE OF):				-
ERIIFICAL	Cause. Enter UNDERLYING CAUSE (Disease or Injury	EOUENCE OF):				
CERTIFICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST					
AL CERTIFICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events OUE TO (OR AS A CONSE		ing cause given in Pe			WERE AUTOPSY FINDINGS
DICAL CERTIFICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST		ing cause given in Pe	PERFORM	IED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL CENTIFICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST		ing cause given in Pe		IED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
MEDICAL CERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST		ing cause given in Pe	PERFORM	IED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL CERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST	rasulting in the underly		PERFORM 1 TYES 2	IED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
ICIAN: MEDICAL CERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reculting in death) LAST DART II. Other eignificent conditione contributing to deeth but not 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	rasulting in the underly 28. OTHER:	PLACE OF DEATH (Check	PERFORM 1 YES 2	IED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
TSICIAN: MEDICAL CERTIFICAL	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST PART II. Other eignificent conditione contributing to deeth but not 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VYES 2 NO NO NO NO NO NO NO NO NO NO	rasulting in the underly 28. 3 □ DOA 4 □ Nursing H	PLACE OF DEATH (Check	PERFORM 1 YES 2	IED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
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ICIAN: MEDICAL CERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reculting in death) LAST DART II. Other eignificent conditione contributing to deeth but not 25. WAS CASE REFERRED TO MEDICAL EXAMINER? Was a case referred to medical	28. OTHER: 3 DOA 4 Norsing H 28b. TIME OF 28c.	PLACE OF DEATH /Check	PERFORM 1 YES 2 [only one) Other (Specify)	IED? □ NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
ICIAN: MEDICAL CERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST DART II. Other eignificent conditione contributing to deeth but not 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inputent 2 ER/Outpatient 1 Netural 5 Pending 1 Netural 5 Pending 2 Accident 3 Suicide 8 Coulette to the suit of the suit	rasulting in the underly 28. 3 □ DOA 4 □ OTHER: 4 □ Nursing H 28b. TIME OF 28c.	PLACE OF DEATH (Check ome 5 Residence 8 (NJURY AT WORK?] YES 2 M NO	only one) Other (Specify) ed. OESCRIBE HOW IN.	JURY OCCURED	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
ICIAN: MEDICAL CERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST DART II. Other eignificent conditions contributing to death but not 25. WAS CASE REFERRED TO MEDICAL EXAMINER? WYES 2 NO 1 Inpetient 2 ER/Outpatient 28e. DATE OF INJURY (Month) Day, Ney) 1 Netural 5 Pending Investigation 28e. DATE OF INJURY (Month) Day, Ney) 389 3	28b. TIME OF LINE WM 1 1 00me, ferm, street, factory, of	PLACE OF DEATH (Check ome 5 Residence 8 (NJURY AT WORK?] YES 2 M NO	Only one) Other (Specify) ed. OESCRIBE HOW IN. Short B1. LOCATION (Street an City or Town, State)	JURY OCCURED A Number or Rural H	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
ED BI PRISICIAN: MEDICAL CERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST DART II. Other eignificent conditione contributing to deeth but not 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	28. 3 DOA 4 Nursing H 28b. TiME OF NURY M 1 00me, ferm, street, factory, of	PLACE OF DEATH (Check ome 5 Reeldence 8 (NJURY AT WORK? YES 2 NO fice 2 (Only one) Other (Specify) ed. OESCRIBE HOW IN. Shot St. LOCATION (Street an. City, or Fown, State)	JURY OCCURED Sed Number or Rural H	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
ED BI PRISICIAN: MEDICAL CERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST DART II. Other eignificent conditione contributing to deeth but not 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	28. 3 DOA 4 Nursing H 28b. TIME OF 28c. NURY M 1 00me, ferm, street, factory, of the coursed at the time, d	PLACE OF DEATH (Check ome 5 Recidence 8 NURY AT NORK? YES 2 NO filee 21	Other (Specify) ed. OESCRIBE HOW IN. 51. LOCATION (Street and City, or Town, State) the cause(e) end menn	JURY OCCURED JURY OCCURED Mumber or Rural II	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Route Number,
ED BI PRISICIAN: MEDICAL CERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inputent 2 ER/Outpatlant 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, decrease of the course of	28. 3 DOA 4 Nursing H 28b. TIME OF 28c. NURY M 1 00me, ferm, street, factory, of the coursed at the time, d	PLACE OF DEATH (Check ome 5 Recidence 8 NURY AT NORK? YES 2 NO filee 21	Other (Specify) ed. OESCRIBE HOW IN. 51. LOCATION (Street and City, or Town, State) the cause(e) end menn	JURY OCCURED JURY OCCURED A Number or Rural II	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Route Number,
ED BI PRISICIAN: MEDICAL CERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST DART II. Other eignificent conditione contributing to deeth but not 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	28. 3 DOA 4 Nursing H 28b. TIME OF 28c. NURY M 1 00me, ferm, street, factory, of the coursed at the time, d	PLACE OF DEATH (Check ome 5 Recidence 8 NURY AT NORK? YES 2 NO filee 21	PERFORM 1 VES 2 only one) Other (Specify) ed. OESCRIBE HOW IN. Show the course of	JURY OCCURED Sed Number or Rural II or ea stated. due to the couse(e	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Noute Number,
LED BI PHISICIAN: MEDICAL CENTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MÄNNER OF DEATN 2 Netural 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or	28. 3 DOA 4 Nursing H 28b. TIME OF 28c. NURY M 1 00me, ferm, street, factory, of the coursed at the time, d	PLACE OF DEATH /Check ome 5 Recidence 8 NJURY AT WORK? YES 2 N NO Ifice 2 Interest and place, and due to , death occurred at the time	PERFORM 1 VES 2 only one) Other (Specify) ed. OESCRIBE HOW IN. Show the course of	JURY OCCURED JURY OCCURED A Number or Rural II	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Noute Number,
DE COMPLETED BI PRISICIAN: MEDICAL CERTIFIC	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 2 Accident 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. SIGNATURE AND TITLE OF CERTIFIER 29c. SIGNATURE AND TITLE OF CERTIFIER 29c. SIGNATURE AND TITLE OF CERTIFIER 29c. SIGNATURE AND TITLE OF CERTIFIER 29c. SIGNATURE AND TITLE OF CERTIFIER	28. TIME OF INLERS. M 1 COMM. Street, factory, of Investigation, in my opinion	PLACE OF DEATH /Check ome 5 Recidence 8 NJURY AT WORK? YES 2 N NO Ifice 2 Interest and place, and due to , death occurred at the time	PERFORM 1 VES 2 only one) Other (Specify) ed. OESCRIBE HOW IN. Show the course of	JURY OCCURED Sed Number or Rural II or ea stated. due to the couse(e	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Noute Number,
DE COMPLETED BI PRISICIAN: MEDICAL CERTIFIC	Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inputer 2 ER/Outpatlant 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or 29b. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITE	28. TIME OF INLERS. M 1 COMM. Street, factory, of Investigation, in my opinion	PLACE OF DEATH /Check ome 5 Recidence 8 NJURY AT WORK? YES 2 N NO Ifice 2 Interest and place, and due to , death occurred at the time	PERFORM 1 VES 2 only one) Other (Specify) ed. OESCRIBE HOW IN. Show the course of	JURY OCCURED Sed Number or Rural II or ea stated. due to the couse(e	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Noute Number,
O DE COMPLETED DI PRINCIAN: MEDICAL CERTIFIC	Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inputer 2 ER/Outpatlant 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 2 See. PLACE OF INJURY (Month) Day, Year (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or 29b. SIGNATURE AND ADDRESS OF PERSON WHO CONFLETED CAUSE OF DEATN (ITE	28. TIME OF INLERS. M 1 COMM. Street, factory, of Investigation, in my opinion	PLACE OF DEATH /Check ome 5 Recidence 8 NJURY AT WORK? YES 2 N NO Ifice 2 Interest and place, and due to , death occurred at the time	PERFORM 1 VES 2 only one) Other (Specify) ed. OESCRIBE HOW IN. Show the course of	JURY OCCURED Sed Number or Rural II or ea stated. due to the couse(e	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Noute Number,
S S COMPLETED BY THIS ICIAIN. MEDICAL CENTIFIC	Cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events recuiting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inputer 2 ER/Outpatlant 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or 29b. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITE	28. TIME OF INLERS. M 1 COMM. Street, factory, of Investigation, in my opinion	PLACE OF DEATH /Check ome 5 Recidence 8 NJURY AT WORK? YES 2 N NO Ifice 2 Interest and place, and due to , death occurred at the time	PERFORM 1 VES 2 only one) Other (Specify) ed. OESCRIBE HOW IN. Show the course of	JURY OCCURED Sed Number or Rural II or ea stated. due to the couse(e	AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO Noute Number,

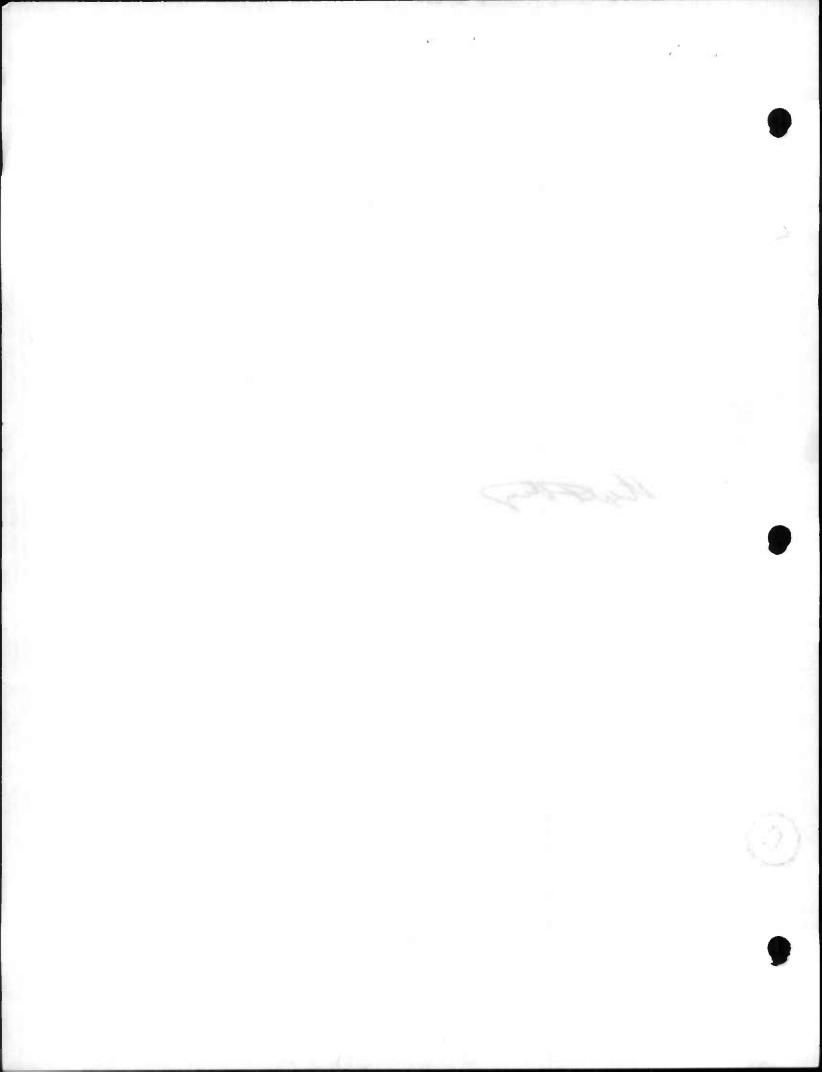


TO THE DOCK TO BE TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FROM BENEATOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direction, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be float within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

#MPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020** SION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIEN		00700
	1. DECEDENT'S NAME (First, Middle, Last)	- 11				2. DATE OF OEATH		3. TIME OF DEATH
	1 Horry	6-//11	Harry H	Griffi	n l	-	4 9	
	4. SOCIAL SECURITY NUMBER	J. JEA	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)
	321-28-8447 9a. FACILITY NAME (If not institution, give	1 [[] M 2 F 5	A YRS.		PR LOCATION OF DEA	May 27, 1	940]	Delaware
DIRECTOR	MALL FT W		u	Jessup			Howard	_
EC	10a. STATE 10b. COUNT	TY	10c. CIT	Y, TOWN OR LOCAT	TION			10d, INSIDE CITY
E	MD How	ard		Jessup				LIMITS?
	10e. STREET AND NUMBER	aru			ZIP CODE		10g CITIZEN	1 ☐ YES 2∜☐ NO OF WHAT COUNTRY?
FUNERAL	Correctional Ins	tituto					USA	OT MILL COOKING
S	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPANI	C ORIGIN? (Specify Ye		RACE — American Indian,
	1 Never Married 2 Married	FORCES? 1 YES		If yes, sp	ecify Cuban, Maxican	, Puerto Rican, etc.)	14.	Black, White, atc.
BY	3 Widowed 4 Divorced			1 123	2 NO Specify:			Specify: White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grad	JCATION le completed)		USUAL OCCUPATION		16b. KIND OF BU	SINESS/INDUST	
91	Elementary/Secondary (0-12)	College (1-4 or 5+)	Itte. Do NOT u	se retired.)	or or working	NI C	1	
₩ I	8th		une	mployed		141,	1	
8	17. FATHER'S NAME (First, Middle, Last)					NE (First, Middle, Maiden	,	
H	Alex Griffin, Sr	•				nie Belle		
2	19a. INFORMANT'S NAME (Type/Print)		1			oute Number, City or Tow		ie)
	Grace E. Dill		Rt.1	Box 90	Greenwood	l, Del 19	950	
	20a, METHOD OF DISPOSITION 1 Burial 2 □ Cremetion 3 □ Ren		netery, crematory or o				CATION — City	
	4 ☐ Donation 8 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI		Greensbo				ensbor	o, MD
	21. SIGNATORE OF FURERAL SERVICE LI	CENSEE			ole-Helfe	un enbein Fun	eral H	ome
	Must	they			_	Greensbor		
	23. PART I. Enter the diseases, or	complications that ceuse List only one cause on e	d the death. Do	not enter the mo	de of dying, such	as cardiec or reap	iratory arreet,	Approximate
	IMMEDIATE CAUSE (Final			1 1				Onset and Death
	disease or condition resulting in death)	Heile	Myo C	evilla	In far.	(Con		
		DUE TO (OR AS A	A CONSEQUENCE O	F):	0			
N	Sequentially list conditions.	b						
Ě	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	A CONSEQUENCE O	F):				
	CAUSE (Disease or injury	C. DHE TO (OR AS A	A CONSEQUENCE O	D.				
Ē	that initiated events resulting in death) LAST	00E 10 (0K A3 A	CONSCOUENCE U	r):				
CERTIFICATION		d						
AL.	PART II. Other aignificent condition	ns contributing to death b	out not resulting	in the underlying	cause given in P	Part I. 24a, WAS AN		24b. WERE AUTOPSY FINDINGS
						PERFOR		AVAILABLE PRIOR TO COMPLETION DF CAUSE
¥								OF DEATH?
ż							- 1	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	NOSSITA.			ACE OF DEATH (Chec	ck only one)		
XS.	1 TYES 2 NO	HOSPITAL:	patient 3 🗆 DOA	OTHER: 4 Nursing Hom	e 5 🗆 Residenca 8	☐ Other (Specify)		
H	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM		URY AT	28d. DESCRIBE HOW I	NJURY OCCURE	D
B	1 Natural 5 Pending 2 Accident Investigation				ES 2 NO			
	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, :	street, fectory, office		281. LOCATION (Street a City or Town, State)	and Number or R	ural Route Number,
	4 Homicide determined							
COMPLETED	29a. CERTIFIER (Check only 1 CERTIFYING PHYS	ICIAN: To the best of my know	ledge, death occurr	ed at the time, date	and place, and due to	o the cause(a) and mar	nner as stated.	
8		ER: On the beels of examination						use(s) and menner as stated.
	296. SIGNATURE AND TITLE OF CENTIFIE	R,			29c. LICENSE NUMB	BER	29d. DATE SIG	GNED (Month, Day, Year)
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일	30. NAME AND ADDRESS OF PERFOR WE	O COMPLETED CAUSE OF DE				,		
	Donate D U	· intans	end	CAT ME				
	31. DATE FILEO (Month, Day, Year)	32. BEGISTPAR'S SIGN Funa Daydoon	ATURE (Armola 00)				_	
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ISION OF VITAL RECORDS, P.O. BOX	
DIVISION OF VITAL RECORDS, P.O. BOX 6	

DIVISION OF VITAL RECORDS, P.O. BOX 68/60,

The INSTITUTOR OF VITAL RECORDS, P.O. BOX 68/60,

The INSTITUTOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be life within 75 persons and beat permit and Mental Hydrene prior to burial, cremation, or removal.

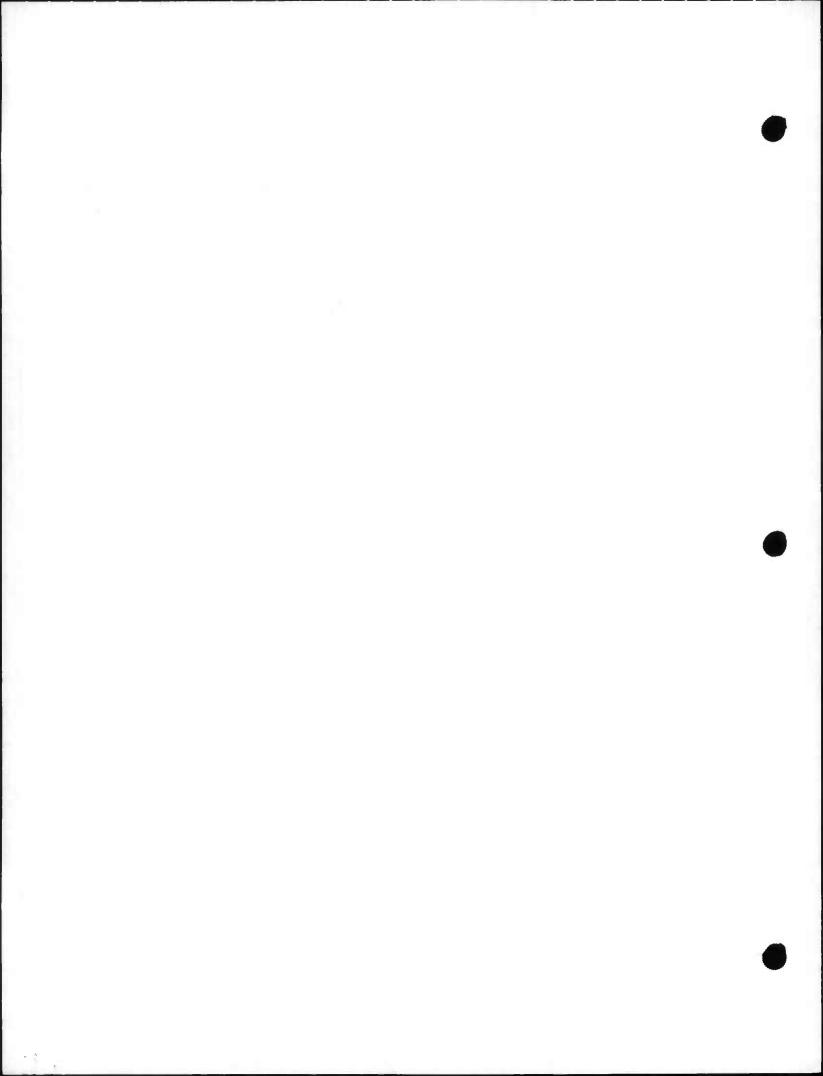
IMPORTANT: It is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

									9	3 (18784			
	FOR 1 - STATE REGISTRAR	STATE OF MARY		PARTMEN IFICAT					GIENE G. NO.					
- 1	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DE	ATH DAY	WEAR.	3. TIME OF DEATH			
	John Wesley	Ε					March 1		YEAR 3	M				
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. lest birtho	fay) IF UND	ER 1 YEAR	IF UNDER		7. DATE OF BIR	TH	8. BIRTI				
	214-09-0479	1 ☑ M 2 □ F 8	6 YR	S. MONTHS	DAYS	HOURS	MIN.	Oct. 4	,	1	"			
	9a. FACILITY NAME (If not institution, give str		9b, CIT	Y. TOWN C	OR LOCATIO	ON OF DEA								
œ	910 Deserte Assess			1.3						IA Co				
DIRECTOR	810 Dewey Avenue			наде	rsto	wn		W	ashir	ngton				
Ĭ Į	10a. STATE 10b. COUNTY		10c.	CITY, TOWN	OR LOCAT	ION					10d. INSIDE CITY			
5	Maryland Wash:	ington		Hage	retor	TYO								
	10e. STREET AND NUMBER	LIIGCOII		nage		ZIP CODE			10a, C	TIZEN OF				
FUNERAL	810 Dewey Avenue					0.1	7.0							
ž	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN II S ADMED	T 42	WAS DEC		740	IC ORIGIN? (Spec	M. M N.					
립	1 Never Married 2 Merried	FORCES? 1 XYES	2 NO	13	If yes, sp	ecify Cuber	n, Mexican	, Puerto Rican, e						
BY	3 Widowed 4 Divorced	W.W.II	DATES		1 U YES	2 ₩ NO	Specify:		,					
Ω	15. DECEDENT'S EDUC	ATION	16a. DECEDEN	T'S USUAL	OCCUPATIO	ON .	_	16h KIND	OF BUSINESS/I		irce			
	(Specify only highest grade of Elementary/Secondary (0-12)	(Give kind	of work done of use retired.	during mo	st of working	g								
COMPLETED	12	College (1-4 or 5+)	mec	hanic				arn	ny depo	t				
8	17. FATHER'S NAME (First, Middle, Last)					18. MOTH	IER'S NAM	AE (First, Middle, I						
0	William Ocher Gro							vielouri Gorname						
B														
유	The state of the s													
	Kit Grove 810 Dewey Avenue, Hagerstown, Maryland 21740 20a, METHOD OF DISPOSITION 20b, PLACE AND DATE OF DISPOSITION (Name of all 20c, LOCATION — City of Town, State													
	1 St Burlai 2 Cremation 3 Removal from State													
	21. SIGNATURE OF FUNDIAL SERVICE LICENSEE Rest Haven Mausoleum 3-18 Hagerstown, Maryland 22. NAME AND ADDRESS OF FACILITY													
1	MINNICH FUNERAL HOME													
	415 E. Wilson Blvd., Hagerstown, Md. 21740													
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
	IMMEDIATE CAUSE (Final Onset and Death													
	disease or condition													
	e. Arteriasclerosclerotic cardio vascular dis. many yrs													
Z	Sequentially list conditions,													
Ĕ	if any, leading to immediate	OUE TO (OR AS	A CONSEQUENC	E OF):										
2	CAUSE (Disease or injury													
E	that initiated events resulting in death) LAST	OUE TO (OR AS	A CONSEQUENC	E OF):										
EB	d.													
2	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													
8						,			ERFORMED?		AVAILABLE PRIOR TO			
								— l¹□ì	YES 2 NO	- 1	OF DEATH?			
Σ								_			1 TYES 2 NO			
AN														
2		HOSPITAL:		OTHE		ACE OF DE	ATH (Che	ck only one)						
YS		1 Inpatient 2 ER/Out		A 4 IN	rrsing Hom		sidence 8	Other (Special	fy)					
F	27. MANNER OF DEATH 1 27 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)												
≽	2 Accident Investigation			М		/ES 2 🗌	NO		_		R 3. TIME OF DEATH M IRTHPLACE (State or Foreign ennsylvania F DEATH ington 10d. INSIDE CITY LIMITS? 1 Yes 2 NO OF WHAT COUNTRY? USA IACE — American Indian, Illack, White, etc. Specify: white Ington Approximate Interval Between Onset and Death MA. 21740 Approximate Interval Between Onset and Death S. Many yrs 24b. Were Autopsy Findings AMALABLE PRIOR TO COMPLETION of CAUSE OF DEATH? 1 Yes 2 NO NED (Month, Day, Year)			
	3 Suicide 6 Could not be determined	28a. PLACE OF INJURY building, etc. (Spe	Y — At home, far	rm, street, fe	ctory, office			281. LOCATION (City or Town,		er or Rural	Route Number,			
ETED BY PHYSICIAN: MEDICA	4 Tromicus Getermined													
필	29a. CERTIFIER 1 CERTIFYING PHYSIC	IAN: To the best of my know	wiedge, death oc	curred at the	time, date	end place,	end due t	to the cause(s) e	nd menner as s	tated.				
O	one) 2 MEDICAL EXAMINER	On the basis of examination	on end/or investig	gation, in my	opinion, d	eath occur	ed at the I	lime, date and pla	ace, and due to	the cause(e) end manner ee stated.			
O I	296. SIGNATURE AND TITLE OF CERTIFIER	60 -11				29c. LICE	NSE NUMI	9ER	29d. D	ATE SIGNED	(Month, Day, Year)			
80	I devel 6	. DIH	cier	1		.DO 1			•					
2	30. NAME AND ADDRESS OF PERSON WHO		March 15, 1993											

111MD 217 W. Washington St. Hagerstown, Md. 21740

Edward W. Ditto
31. DATE FILED (Month, Day, Year)
MAR 15 1993

Sinden-Rudal

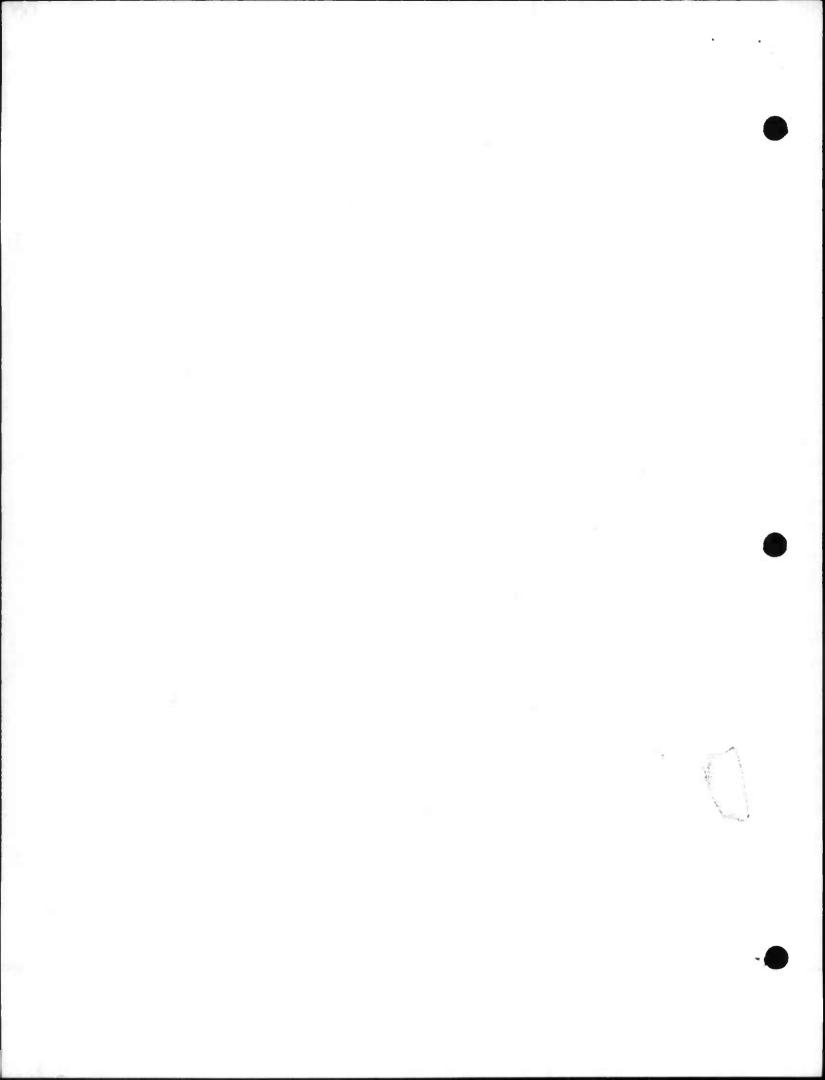


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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

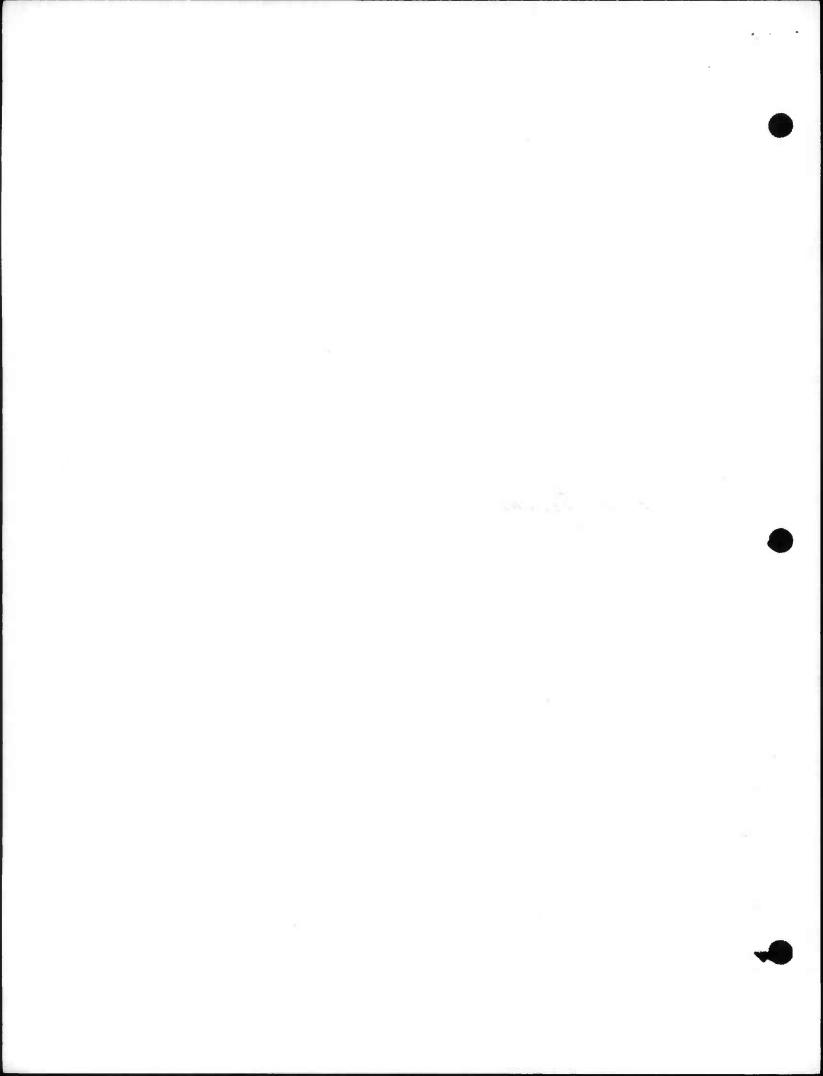
CERTIFICATE OF DEATH.

		1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		NENTAL HYGIEN	E	00700			
		1. DECEDENT'S NAME (First, Middle, Last) Irma Re	uth Goe	12			2. DATE OF DEATH DO	6 99				
2		4. SOCIAL SECURITY NUMBER 228-18-0103	1 - M 2 - F 7	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 12/31/1914		BIRTNPLACE (State or Foreign Country) Larvland			
2, 3 should	TOR	96. FACILITY NAME (If not institution, give so 39 York Road RESIDENCE OF DECEDENT	reet and number)			or location of dea Deposit	ATN	Cecil	OF DEATN			
obysician. burlal-transit permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY Maryland Ceci	_		ry, TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 YES 2 NO			
n. ansit permi	FUNERAL	100. STREET AND NUMBER 39 York Road			101	21904		10g. CITIZEN	OF WHAT COUNTRY?			
	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 XNO	II yes, sp	ENDENT OF HISPANI ecify Cuban, Maxican 2 NO Specify:	C ORIGIN? (Specify Yea , Puerto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify: White			
hospital or attending ached for use as the ce.	LETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u		st of working	16b, KIND OF BUS					
the hospit detached once.	COMPL	12 17. FATHER'S NAME (First, Middle, Last)	0	Civi	Service		U.S. IE (First, Middle, Maiden	Govern	ment			
# 8 £	BEO	Frank Todd				Madal	eane Flet	tcher				
ay be retained bage 5 should be notified	5	19a. INFORMANT'S NAME (Type/Print) George W. Goetz 20a. METNOD OF DISPOSITION		39 Yo	ork Rd.	Port De	posit, MD	21904				
me 6 m		20s. METHOU OF DISPOSITION 1 1 Surial 2 Cremation 3 Remote 4 Donation 5 Other (Specify) 21. Signature Of Funeral Service Lice	oval from State Com		of DISPOSITION (Na other place) MOTIAL (Gardens	3/19 Be	l Air,	or Town, State Maryland			
9 - 9		* Harry Di	Gran	~	Tarr: Aberd		Funeral H yland 2100		.A.			
within 24 hours npletely filled in cremation, or n		23. PART I. Enter the diseases, prospective. I	omplications that caused let only one cause on e	ach line.					Approximate Interval Between Onset and Death			
th certificate be execu ending physician and I Hygiene prior to bur or other traumatie	CERTIFICATION	Sequentially list conditions, if any, loading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):										
w requires that the been signed by the rt. of Health and M	MEDICAL	PART II. Other significant condition	s contributing to death b	ut not resulting	in the underlying	g cause given in F	Terrification of the second se	MED7	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF GLATTY? 1 YES 2 NO			
SICIAN: The law certificate has to the State Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1.35-YES 2 - NO	HOSPITAL:	etlent 3 🗆 DOA	OTHER:	ACE OF DEATH (Chec						
The with	ВУ РНУ	27 MANNEH OF DEATH 1	26s. DATE OF SUURY (Month, Day, Sar)		M 1 1	PRKT YES 2 NO	28d. DESCRIBE HOW I	NJURY OCCURE	D			
OR ATTENDING DIRECTOR; After hours after death	8	3 Guitcide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec		28t. LOCATION (Street and Number or Rural Route Number, City or Swert, State)							
7 40 =	COMPLET		HAN: To the best of my knowless on the basis of examination						use(a) and manner as stated.			
TO THE HOSPITA TO THE FUNERA DE FIED WITHIN 7.	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	hain, V	n-12		29c. LICENSE NUME	779	≥ 3	NED (Month, Day, Year)			
		W. Bruce &	COMPLETED CAUSE OF DE	in M.	Print) U.	sion Ho EIK to.	n Ma	levil	· Connil			
-		MAR 1 8 93	32. REGISTRAR'S SIGN	LOON-AMOLE	r.							



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DIVISION OF VITAL RECORDS, P.O. BOX 13146,	PHYSICIAN:
VISION	Tal OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within
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		FOR STATE REGISTRAR	STATE OF MA				F HEALTH AND	D MENT	AL HYGIENI REG. NO.	E			
1	i	1. DECEDENT'S NAME (First, Middle, Last)						MO	TE OF DEATH	Y YE		TIME OF DEATH	
		Marie D. Gr	coton					Ma	arch 10	, 1993		3:20 P M	
		4. SOCIAL SECURITY NUMBER		AGE (In yrs. la		MONTHS DA		(Mc	re of BtRTH onth, Day, Year)	0		CE (State or Foreign	
모		219 18 0218	1 M 2XXF	69	YRS.				5/5/192			4	
	H.	99. FACILITY NAME (If not institution, give st				9b. CITY, TO	or location of Snow Hi						
42	5	220 W. Federal			1								
Pages	E	10e. STATE 10b. COUNTY			10c. CITY	, TOWN OR L					- 21	LIMITS?	
mit.		Maryland Wor	rcester			Snow	H111 tor, ZIP CODE		-	10a CITIZEN			
it per	RA		Gh				21863)				COOKINII	
cian. I-trans	N.	220 W. Federal 11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. AI	RMEO	13. WAS	DECENDENT OF HIS		GIN? (Specify Yes	or No- 14.	RACE -	Amarican Indian,	
physi	- 1	1 Never Merried 2 Married	FORCES? 1 []		NO		s, specify Cuben, Me YES 2 XXNO Sp		to Rican, atc.)		1-1-1	hite, etc.	
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ital or		Elementery/Secondery (0-12)	College (1-4 or 5+)	m		_			0				
hosp lached	ME	12. 17. FATHER'S NAME (First, Middle, Linst)			Homen	naker	18 MOTHER'S	NAME /Elm	ot. Middle, Maiden		_		
y the			11-						eller	Summer			
ould be	00	Milton Danzeg. 19a. INFORMANT'S NAME (Type/Print)	LOCK	19	Db. MARLING	ADDRESS (St				n, State, Zip Coc	(0)		
5 sh	유	T. Clay Groton	.Tr		220 1	J. Fed	eral St.	Sno	w Hill.	Marvla	and	21863	
page		200, METHOD OF DISPOSITION			OF DISPOS		of cemetery, crematory						
e 6 m ector,		1 X Buriel 2 Cremetion 3 Remo	oval from State	All F	Hallov	s Epi	scopal Ce	emete	ry Sn	ow Hil	l, M	aryland	
ral di	- 1	21. SIGNATURE OF FUNEBAC SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Dennis Funeral Home											
death fune i.		1 Voyage St	hours			1			_	Hill,	Md.	21863	
by the		23. BART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
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be or la	AT	If any, leading to immediata cause. Enter UNDERLYING	DOE TO (O	R AS A CONSE		F):							
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een si of He	THE HOSPITAL OR ATTENDING PHYSICIAN: the law requires that the osean cermitate be executed within 4.7 and 8 and 10										1 (YES 2 NO	
e law has bi Dept.	AN	25. WAS CASE REFERRED TO MEDICAL			-		20. PLACE OF DEATH	(Check only	v one)	Solution 1993 3. Time of Death 3:20 P 3:20 P 3:20 P 23 Maryland 9c. Country) Maryland 9c. Country of Death Worcester 10d. Inside City Limits? 1			
V: The icate State	i i	EXAMINER? 1 YES 2 NO	HOSPITAL:	R/Outnetlant	3 🗆 DOA	OTHER:	Home 5 - Realder						
Sicial certif	¥	27. MANNER OF OEATH	26s. OATE OF th	JURY	28b. TIM	E OF 28	c. INJURY AT	_		NJURY OCCUR	ED		
r this h with		1 Natural 5 Pending	(Month, Day,	Year)	INJ	M 1	WORK?						
NOING I: Afte r dear	ا م ا	2 Accident investigation 3 Suicide 6 Could not be	26e. PLACE OF 1 building, etc	INJURY — At h	ome, farm,	street, factory,	office		OCATION (Street of Street of Town, State)		Rural Rout	e Number,	
ATTE ECTOF S afte	⊢	4 Homicide determined											
TAL OR VAL DIRI 72 hour It iten	MPLE	one)	ICIAN: To the best of m								usele) er	nd manner ee stated.	
HOSP FUNE within	8	29b, SIGNATURE AND TITLE OF CERTIFIE					29c, LICENSE						
IN POR	0	when a Route	ubers a	10.			D 15	85	7	▶ 3/	2/9	3	
		30. WAME AND ADDRESS OF PERSON WH	OCOMPLETED CAUSE	OF DEATH (IT	EM 27) (Type	Print)	54.511	1360	ru Hil	218	101		
		31. DATE FILED (Month, Day, Year)		S SIGNATURE			,	-	-	-			
		MAR 12 1993	Jahre Dar	in for									



FOR

	- REGISTRAR		CE	RTIF	ICATE OF	DEATH	1924	REG. NO.	200	4/93		
1	1. DECEDENT'S NAME (First, Middle, Last)		0			-	2. DATE OF	DEATH	ME 5	3. TIME OF DEATH		
- 1	Joseph Port	erfield	(xass	Ma	w l		ВОНТН	15	9 3			
	4. SOCIAL SECURITY NUMBER		. AGE (In yrs. last		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF		8. BI	RTHPLACE (State or Foreign		
	219-14-9196	1 XM 2 F	68	YRS.	MONTHS DAYS	HOURS MIN.	9 2			MD		
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TOWN	OR LOCATION OF			c. COUNTY O			
8	Carroll Count	v Gen. Ho	ospita	17	West	tminste	יד		Car	roll		
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT											
DIRECTOR				10c. CIT	Y, TOWN OR LOCA					10d. INSIDE CITY LIMITS?		
- 1		rroll				tminste	er			1 TES 2 NO		
MA I	10e. STREET AND NUMBER	D3			10	f. ZIP CODE		10		OF WHAT COUNTRY?		
FUNERAL	1804 Bollinge	7				21157			US			
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT I FORCES? 1 7 IF, YES, GIVE, WAR	YES 2 N	MED	If yes, sp	CENDENT OF HISP secify Cuban, Mexi	can, Puerto Rici		No- 14. R	ACE — American Indian, llack, White, etc.		
E I	3 Widowed 4 Divorced	WW II	R OR DATES		1 🗆 YES	NO Spec	olfy:		s	white		
	15. DECEDENT'S ED	UCATION	16a. DE6	CEDENT'S	USUAL OCCUPATION	ON	16b. KI	ND OF BUSINE	SS/INDUSTR			
E I	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gir ilfe.	ve kind of Do NOT u	work done during mo se retired.)	ost of working		UFUTICATION				
립	12	consecutive constraints	of	fic	e manag	rer	M	other	Goo	88		
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)					18. MOTHER'S						
	George L. Gas	sman				Julia		Russe				
BE	19a. INFORMANT'S NAME (Type/Print)		196	. MAILING	ADDRESS (Street a)		
은	Mrs. Marian G	assman	1	804	Bollin	nger Ro	. We	stmin	ster	MD 21157		
	20- METHOD OF DISPOSITION		20b. PLACE A	NDDATE	OF DISPOSITION (N	ame of	DATE	20c LOCAT	ION - City o	Town State		
	1.4 Burial 2 Cremation 3 Rer 4 Donation 6 Other (Specify)	noval from State	Ever g	matory or o	n Memor	rial Gr	18 3/1	8 Fi	nksbi	urg, MD		
	21. SIGNATURE OF FUNERAL SERVICE L	JCENSEE			22 NAME A	NO ADDRESS OF	FACILITY					
- 1	Debend II	T-2 4.4.			Pri	tts Fur	eral	Home	& Cn	apel		
	Robert K. Pritts. Sr. 412 Washington Rd., Westminster, N 23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
ATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	B. ARTO	AS A CONSEC	DUENCE O	わ: DT7 C_ /ta			÷===				
RTIFIC	CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (D	R AS A CONSEQ	NUENCE O	F):							
Ö	PART II. Other aignificent condition	one contributing to de	anth hut not a	anultina.	In this conduction		- Post Lo		. I			
₹	TAIT II. Other arginitedit condition	to de	eath but not n	eauting	in the underlyin	g ceuse given i	n Pairt I. 24	PERFORME		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE		
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Σ							—			1 YES 2 NO		
AN	25. WAS CASE REFERRED TO MEDICAL											
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	2 Accident Investigation T T YES 2 NO											
	3 Suicide 6 Could not be 4 Homicide determined	building, etc	c. (Specify)	ire, iarrii,	street, factory, diffic	•		own, State)	Number or Hu	ral Route Number,		
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATI		SICIAN: To the best of m										
			minimum and/or li	rrvestigatio	on, in my opinion, o	seath occured at the	ne time, data an	d place, and du	e to the cau	ee(s) and manner as stated.		
шШ	296. SIGNATURE AND TITLE OF CERTIFIE	ER				29c. LICENSE N		29	- 1	NED (Month, Day, Year)		
- 111	(Frank 1)	trulen	en .			りしフェ	40	'	211	7/93		
	30. NAME AND ADDRESS OF PERSON'S				Print)	s NES	inius	TON 1	naste	ornas		
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S	S SIGNATURE									
III.	CO' 7 1 044	10	K .	70								

TO THE HOSPITAL OF VITAL RECORDS, P.O. BOX 68760,
TO THE HOSPITAL OF THE WAYLAND 21215-0020
TO THE HOSPITAL OF THE WAYLAND 21215-0020
TO THE FUNEFAL PHENCY AND THE WAYLAND PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNEFAL PHENCY AND THE WAYLAND TO HOSPITAL THE PROPERTY OF HOSPITAL PHYSICIAN WHITH THE STATE DEPT. OF HOSPITAL PHYSICIAN OF THE WAYLAND THE WAYLAND TO HOSPITAL PHYSICIAN OF HOSPITAL PHYSICI

DHMH-16 Rev 1/89

2, 3 should

31. DATE FILEO (Month, Day, Year) MAR 2 9

1993

1 - STATE REGISTRAR	STATE OF	MARYLAND						MENTAL	HYGIEN REG. NO	IE .		1878	0
1. DECEDENT'S NAME (First, Mic	Idie, Last) No name	No name given infant girl 2. DATE OF IMPORTS NARCO MARCO								AY	YEAR	3. TIME OF DEATH 7:35 A	TH
4. SOCIAL SECURITY NUMBER N/A	5. SEX	6. AGE (In yrs. I	last birthday) YRS.	IF UNDE	DAYS	IF UNDER	MIN.	7. DATE (of BIRTH , Day, Year) ch 7,	1993	8, BIRTHP Country	PLACE (State or i	ereign Oreign
90. FACILITY NAME (If not institu SHADY GROVE RESIDENCE OF DECE	ADVENTIST HO	SPITAL			Y, TOWN O		05 ON OF DE		cn /,	9c. COUR	MARY OF DE		
	MONTGOMERY				OR LOCAT							10d. INSIDE CIT LIMITS? 1 XYES 2	
100. STREET AND NUMBER 28 STARBOARD	CT.				101.	208						HAT COUNTRY?	
11. MARITAL STATUS 1 Never Married 2 Mei 3 Widowed 4 Divorced	FORCES?	NT EVER IN U.S. A 1 YES 2 WAR OR DATES		13.	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Ye If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: N/A						USA s or No- 14. RACE — American Indian, Black, White, etc. Specify: Asian		
15. DECEDE (Specify only hig Elementary/Secondary (0-12)		(Give kind of a	IT'S USUAL OCCUPATION of work done during most of working IT use retired.) 18b. KIND OF BUSIN										
N/A 17. FATHER'S NAME (First, MANN) Behro		_		N/A			A Sumeme)						
190. INFORMANT'S NAME (Type/ SEE ABOVE			Katayoon Alavi Hadavi										
20a. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of GROVE ADV. HOSP. 20c. LOCATION — City or Town, State ROCKVILLE													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE VICE President 22. NAME AND ADDRESS OF FACILITY 20850- 9901 Medical Center Dr., ROCKVII										KVIL			
23. PART I. Enter the disease or condition resulting in death)	a. Abru	ne.	nta	•				enta)	iratory arr	oat,	Approxin Interval I Onset ar	letwe	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Chorio amnionitis) DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): d.													
PART II. Other algoriticant conditions contributing to deeth but not resulting in the underlying cause given in F								Part I.	Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 MHO			WERE AUTOPSY: AVAILABLE PRIOR COMPLETION OF DEATH? 1 YES 2	CAUSE
25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outcetlant 3 DOA 4 Murring More 6 Residence 6 Other (Section)													
						Munsing Hame 5 G Residence 6 F 28c. INJURY AT WORK? M 1 G YES 2 G NO				e Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED N/A			
3 Suicide 6 Cou 4 Homicide dete	home, farm, a N/A	me, farm, street, factory, office					261. LOCATION (Street and Number or Bural Route Number, City or Town, State) N/A						
	NG PHYSICIAN: To the best of EXAMINER: On the best of											and manner se	stated,
296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (M) 34098 3/7/													

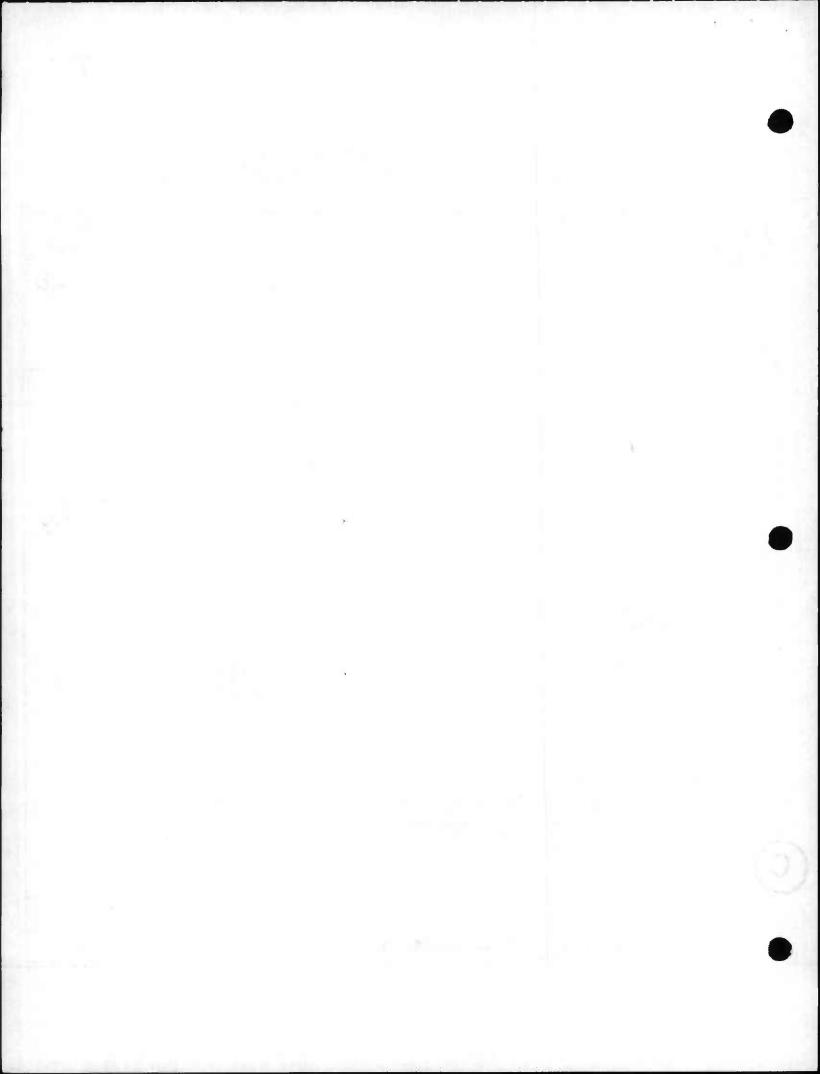
DOCTORS I

Mandell

DRIVE

29878

GERMANTOWN, MD

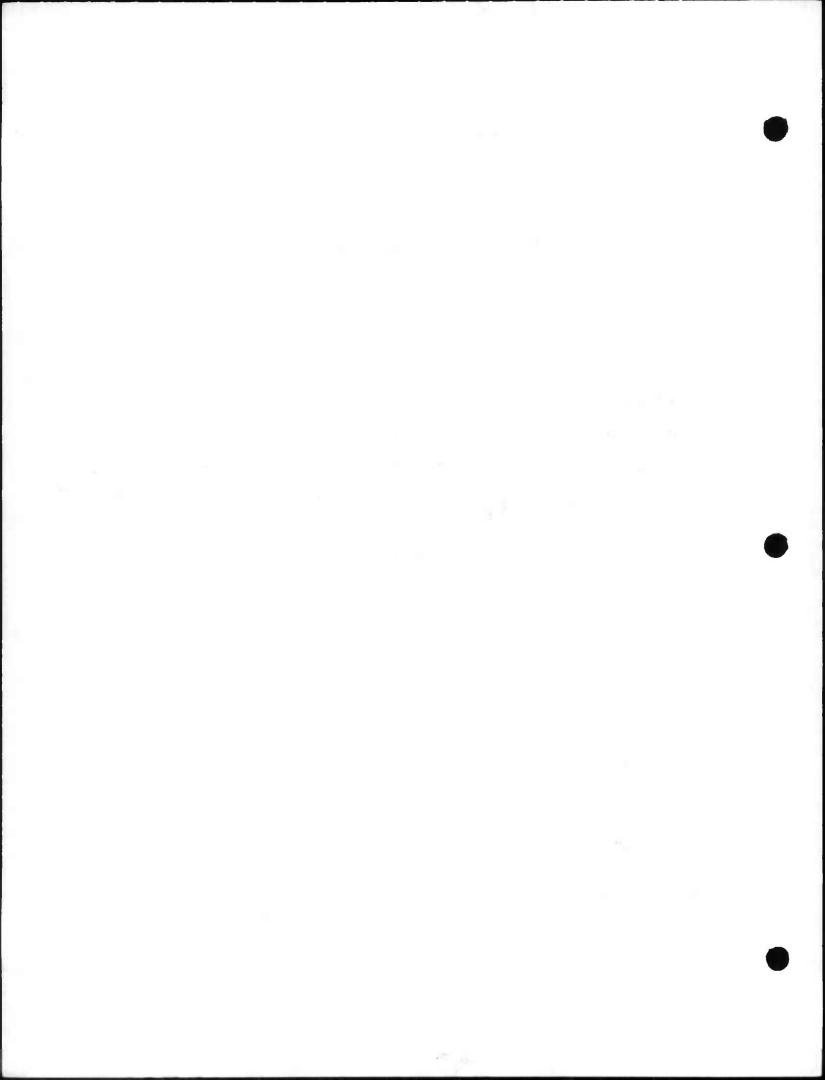


68760,	
BOX	
P.O.	
RECORDS,	
OF VITAL	
VISION	

	15, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	CIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	entificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
3	DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certific	TO THE TAX THAT CIRECTOR. Amen this certificate has been signed by the attending plant to the filed within 72 nowing plant of the man the State Dept. of Health and Mental Hygiens	IMPORTANT, If item 28 is marked, or item 23 shows any injury, or other

							93	3 08789
	FOR 1 - STATE REGISTRAR	STATE OF MARYL			HEALTH AND			
	1. OECEDENT'S NAME (First, Middle, Last		OLITITI	OAIL O	DLAIII	REG. N	0.	3. TIME OF DEATH
	ALFRED A. HAERING	מע					DAY	YEAR 5 55 0
1			(In yrs. last birthday)	IF UNDER 1 YEAR		05	1 4	3 3.33 7
			Vee	MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)
	370 07 3432	1 M 2 D F	85 YRS.			DEC. 20,	1907	FRANCE
-	9a. FACILITY NAME (If not institution, give stre	et and number)		9b. CITY, TOW	N OR LOCATION OF D	EATH	9c. COUN	ITY OF DEATH
0	SUBURBAN HOSPITAL			BETHE	SDA		MONT	GOMERY
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		400 CITY	TOWN OR LOC	2471011			
=		01/771		,	ATION			10d. INSIDE CITY LIMITS?
	MARYLAND MONTGO	UMERY	BET	HESDA				1 TES 2XX NO
FUNERAL					101. ZIP CODE		10g. CITIZ	ZEN OF WHAT COUNTRY?
	10134 CRESTBERRY I				20817		UNIT	ED STATES
1 2	11. MARITAL STATUS 1 Never Married 2 A Married	12. WAS DECEDENT EVER II FORCES? 1 X YES	U.S. ARMED	13. WAS D	ECENDENT OF HISPA specify Cuban, Maxico	NIC ORIGIN? (Specify Y	as or No-	14. RACE — American Indian, Black, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES		ES 2XXNO Specif			Specify:
ED E	TV	WORLD WAR I						WHITE
ETE	15. OECEDENT'S EDUCA (Specify only highest grade co	ompleted)	16a. DECEDENT'S I	JSUAL OCCUPA ork done during in telired.)	TION most of working	16b. KIND OF B	USINESS/INDU	USTRY
2	Elementary/Secondary (0-12)	College (1-4 or 5+)						
COMPL		2	RESTAUR	ANTEUR		RESTA	JRANT	
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maide	n Sumame)	
H	ERNEST HAERINGER					OHRESSER		
2	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or To		
_	MARGARET H. HAERIN		10134	CRESTI	BERRY PLA	CE, BETHES	SDA, M	ARYLAND 20817
	20e. METHOD OF DISPOSITION 1 Burial 2 Cremetion 3 Remove	al from State	PLACE AND OATEO	F DISPOSITION /	Name of 2 /12 /	O OATE 20c. L		Sty or Town, State
	4 Donetten 5 Other (Specify)	A M	IONTGOMER	Y CREMA	ATORIUM,	INC. BET	THESDA	, MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LICEN			22. NAME	AND ADDRESS OF FA	CILITY ROBERT	' A. P	UMPHREY FUNERAL
	1 David E.	-M11.	M00803	11OML)	DETHEODY	-CHEVI CHA	DE, I	NC. /55/
	23. PART I. Enter the diseases, or con	mplications that cause		12000	ONSIN AVE	NUE, BETHE	SDA, I	MARYLAND 20814
	snock, or neert tellure. Lis	st only one ceuse on e	ach line.	or entrer the n	node of dying, suc	n es cerdiec or res	piratory sire	est, Approximate interval Between
	IMMEDIATE CAUSE (Finel disease or condition	G AR DIAG	ADDE	CT				Onset and Death
	resulting in death) e.	DUE TO (OF AS	CONSEQUENCE OF	<i>></i> 1				
		HUDAVAL	CM IC	HOC	L			
O	Sequentisity list conditions, b.	DUE_TO (OR AS A	CONSEQUENCE OF	21100	1)			
AT	If sny, lesding to immediate cause. Enter UNDERLYING	Q PPTIC	SHOC	2				
은	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF					
ERTIFICATION	resulting in deeth) LAST	TOVIC	MEGA	COLOR				j
l li	d.	10010	12011					
4	PART II. Other significant conditions			the underlyi	ing ceuse given in		N AUTOPSY	24b. WERE AUTOPSY FINOINGS
MEDICAL	CLOSTRIDIUM DIF	FICIL E	NTERO CO	LITIS,	ISCHEN	1 VES	PRMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
Ä	BOWEL , DISSE	MINATED 11	NTRA-VAS	CULAK	2 MARINE	DPATHU		OF DEATH?
	RENAL FALLY	P.F.		-401	10114			1 TYES 2 NO
₹	25. WAS CASE REFERRED TO MEDICAL	100		28.	PLACE OF DEATH (Ch	ack anty one)		
PHYSICIAN:	EXAMINER?	IOSPITAL:		OTHER:				
Ě	27. MANNER OF DEATH	28a. DATE OF INJURY	28b, TIME		ome 5 - Residence	6 ☐ Other (Specify) 28d. OE\$CRIBE HOW	IN ILIEN OCCI	IDEA
	1 Netural 5 Pending	(Month, Day, Year)	INJU	IRY V	YORK?	200. OEJONIBE NOW	INJUNI OCCI	ONED
BY	2 Accident Investigation 3 Suicide Could not be	28e, PLACE OF INJURY	- At home, farm, at			26f. LOCATION (Street	and Number	ne Drumi Doube Mumber
	4 Homicide determined	building, atc. (Spec	ffy)			City or Town, State	e)	ar nurer noute number,
COMPLET	29a, CERTIFIER							
I de	(Check only	AN: To the beat of my know						
8	2 MEDICAL EXAMINER:	On the besia of examination	and/or investigation	, in my opinion,	death occured at the	time, data and place, a	ind due to the	cause(a) and menner as stated.
w.	THE STUMETURE AND TITLE OF CERTIFIER	^			29c. LICENSE NUI	MBER	29d. DATE	SIGNED (Month, Day, Year)
B	My avere, M.	()			D265	71 MD	▶ 3	112/93
2	do hame and address of PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)	10 11	C 11	0.	CHICCOA MO
	IRVING /VIZ	USIMD	5413	, Jel	HR LAN	E #206	C BE	ETHESPA, MD
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGN						~~~
	MAR 16 '93	Julia Davida	A. Brode St.					
			THE RESERVE AND PERSONS ASSESSED.					

DHMH-16 Ray 1/89



TO THE HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours efter death. Page 6 may be retained by the hospital or attending physician.

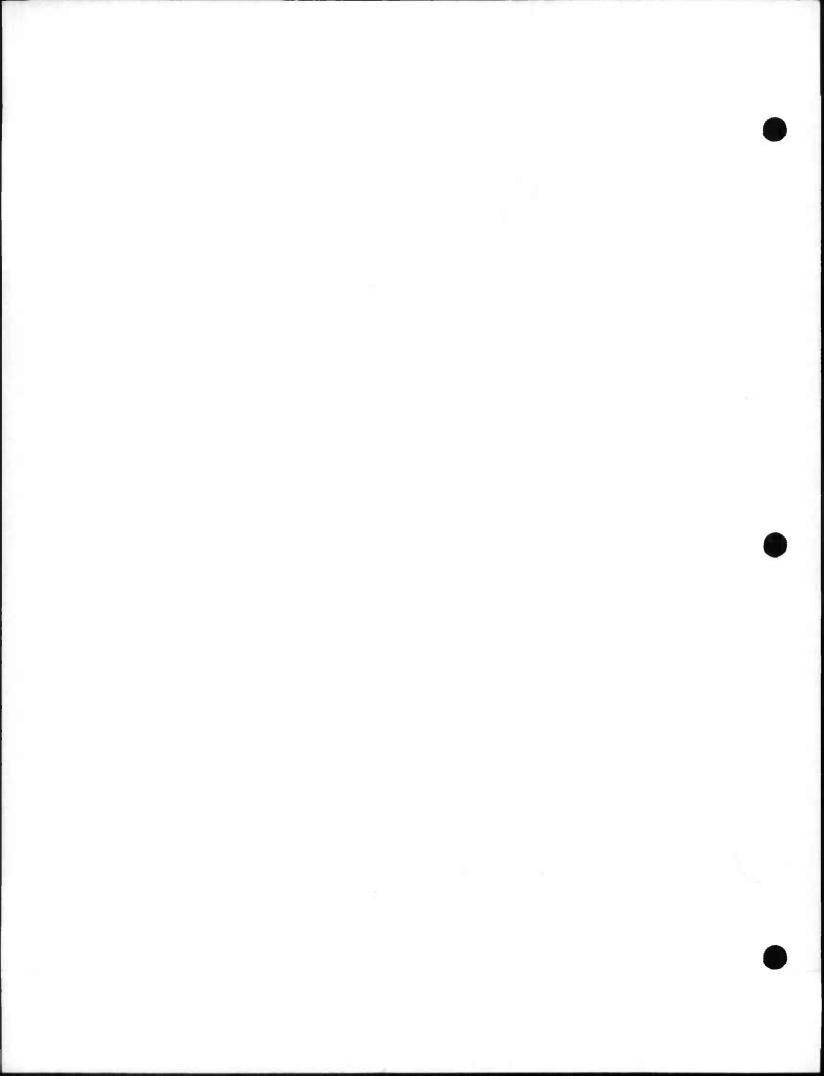
TO THE PART OF THE AREA OF THE AREA OF THE ATTENDING PHYSICIAN AND COMPLETED AND COMPLETED AND THE THINK OF THE AREA OF THE ATTENDING PROPERTY. If the ATTENDING OF THE ATTENDING PROPERTY. If the ATTENDING OF THE ATTENDING OF

BALTIMORE, MARYLAND 21215-0020

VIVISION OF VITAL RECORDS, P.O. BOX 68760,

STATE	0F	MARYLAND	/ DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
		C	ERTIFICATE	O	F DEAT	TH		REG. NO.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			IENTAL HYGIEN		
- 10	1. DECEDENT'S NAME (First, Middle, Last)				T	2. DATE OF DEATN		3. TIME OF DEATN
	Francis Marion	Huggins, Jr.				MONTH DA	1993	12:15 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)	8. BIRT	INPLACE (State or Foreign
	034-14-3487	1 🖹 M 2 🗆 F 8	1 YRS.	DAYS DAYS	HOURS MIN.	Jan. 26,	1912 Sou	th Carolina
	9a. FACILITY NAME (If not institution, give		9		R LOCATION OF DEA	ATN	9c. COUNTY OF	
6	9916 Hillridge D	rive		Kensi	ngton		Montgo	omery
EG	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Υ	10c, CITY, 1	OWN OR LOCAT	ION			10d, INSIDE CITY
DIRECTOR	Maryland Mon	ntgomery		Kensing	ton			LIMITS?
AL	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	9916 Hillridge I	rive			20895		United	States
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPANI	C ORIGIN? (Specify Yes	or No- 14. RA	CE — American Indian, ck, Whita, etc.
ВУ	1 Never Married 2 Merried 3 Widowed 4 Divorced	1931-1947		1 TES	cify Cuben, Mexican, 2 KNO Specify:	, Puerto Hican, etc.)		White
	15. DECEDENT'S EDI		16a. DECEDENT'S US	IIAL OCCUPATIO		I m man or m	<u> </u>	MILTE
COMPLETED	(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kind of wor	k done during mos	st of working	166. KIND OF BU	SINESS/INDUSTRY	
립	Entrovally (0-12)	1	Realto	r		Real	Estate	
Š	17. FATHER'S NAME (First, Middle, Last)		-		18. MOTHER'S NAM	E (First, Middle, Maiden	Surname)	
BE (Francis Marion	Huggins, Sr.			Flora	Barnes		
2	19e. INFORMANT'S NAME (Type/Print)					oute Number, City or Tow		
	Helen H. Huggins							land 20895
	20a. METHOD OF DISPOSITION 1 ABurlal 2 Cremation 3 Ren	noval from State 20b	PLACE AND DATE OF I	DISPOSITION (Na	me of 3/16/93	DATE 20c. LO	CATION — City or	
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI		riington	Nationa	1 Cemeter	ry Arii		Virginia
	0.1.	/	M00198	Rober	A. Pump	hrey Fune	ral_Home	20814-3501
	Maring V	touch		7557 7	visconsin	Ave., Bet	hesda,MD	20814-3501
	23. PART I. Enter the disesses, or shock, or heart failure.	complications that caused List only one cause on ea	I the death. Do not sch line.	enter the mod	de of dylng, such	ss cardisc or respi	iratory srrest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition							Onset and Death
	resulting in death)	a	Cancer CONSEQUENCE OF:					7 months
_		DUE TO (OR AS A	CONSEQUENCE OF):					
힐	Sequentially list conditions, if any, leading to immediate	DUE TO (DR AS A	CONSEQUENCE OF):					
3	cause. Enter UNDERLYING CAUSE (Disease or injury	c						
[[that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION	resulting in death) Exst	d						
AL O	PART II. Other significant conditio	ns contributing to death b	ut not resulting in	the underlying	cause given in P			b. WERE AUTOPSY FINDINGS
	Parkinson's Di	sease				PERFOR		AMILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC								OF DEATH?
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PL	ACE OF DEATH (Chec	ck only one)		
ΙΧSΙ	1 TYES 2 NO	1 Inpetient 2 ER/Outp	atient 3 DOA 4	☐ Nursing Home	5 N Residence 6			
표	27, MANNER OF DEATN 1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME C	Y WOI	RK?	28d. DEŞCRIBE NOW I	NJURY OCCURED	
BY	2 Accident Investigation	28e. PLACE OF INJURY	— At home form stre		ES 2 NO	261. LOCATION (Street a		
ED	4 Homicide 6 Could not be determined	building, etc. (Spec	ify)	et, factory, office		City or Town, State)		Houte Number,
COMPLET	29a. CERTIFIER 1 X CERTIFYING PHYS	ICIAN: To the best of my know	and double lands					
₩.		ER: On the basis of examination						(a) and manner as stated
	296. SIGNATURE AND THE OF CERTIFIE		Α.		29c. LICENSE NUMB			
BE	(1) V. 10	- ILL	1 W	>	MN #33,			1 12, 1993
2	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CAUSE OF DE	ATN (ITEM 27) (Type, Pri	int)			L. Hard	- 12, 1773
	Andrew K. Vaaler	, M.D. Pulmon	nary Divis	sion, N	NMC Beth	nesda, Mar	yland 2	20889
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	ATURE					
	MAR 16 '93	Gicha Davida	A Rondo DD					

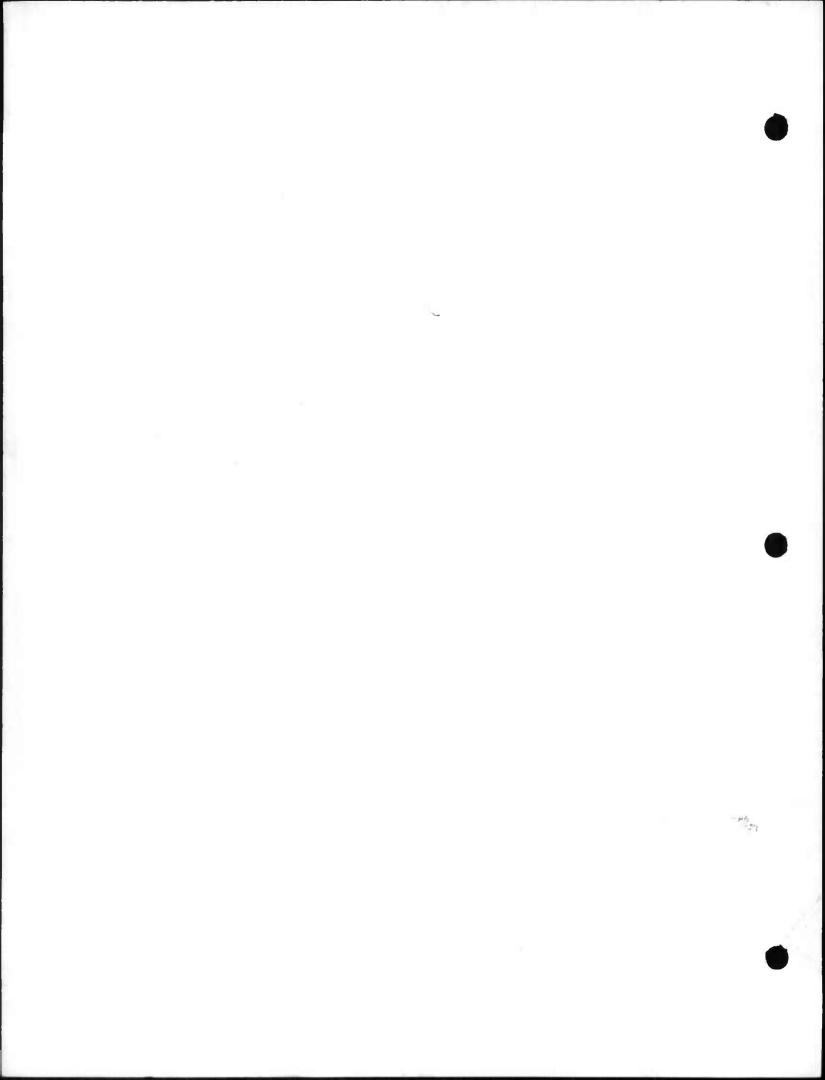


D VISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE WASTER OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

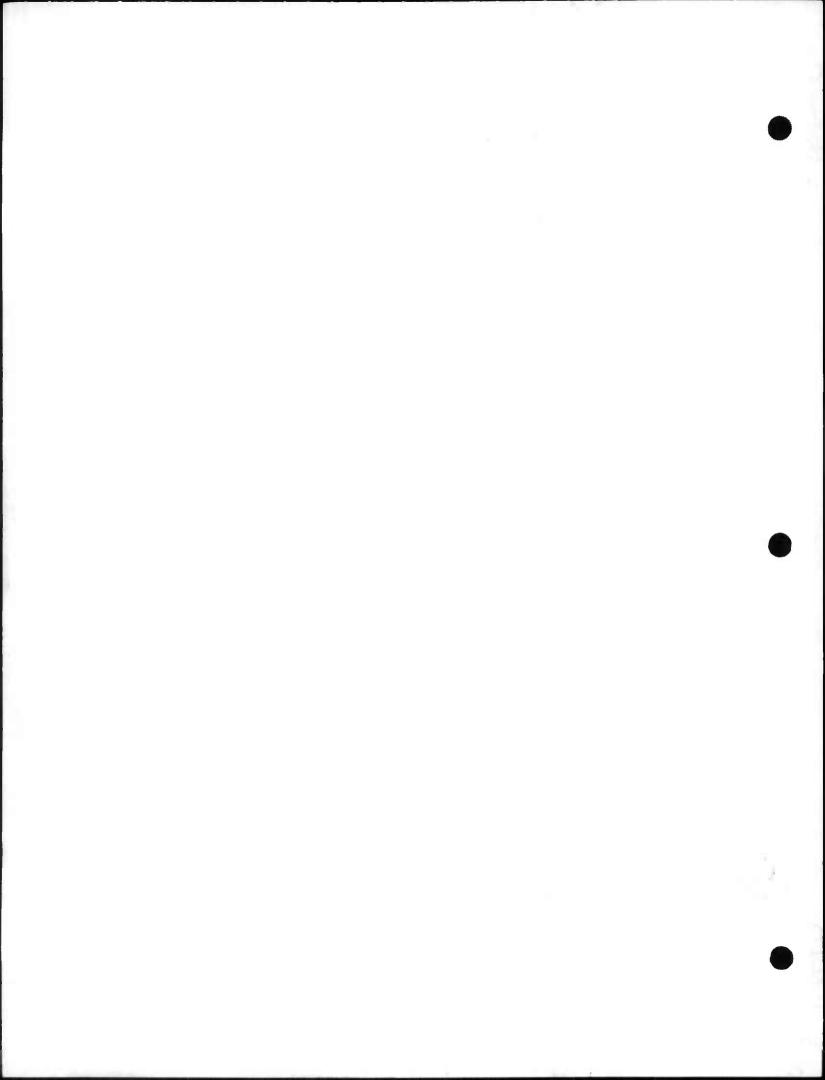
TO THE WASTER CHARTER HECTOR: After this certificate has been signed by the attending physician and completely filled in by the huneral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filed. The marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR		CERTIF	CALE OF	DEATH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last) MILDRED	М.	НОІ	RN	-	2. DATE OF DEATH DO O O		year 3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 5.	. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			9317:20 A M BIRTHPLACE (State or Foreign	
	250-84-2607 1 9a. FACILITY NAME (If not institution, give street	□ M 2 🙀 F	43 YRS.	MONTHS DAYS	HOURS MIN.	Nov. 8, 1	949 S	outh Carolina	
DIRECTOR	13502 NORTHGATE				OR LOCATION OF D			Y OF DEATH I'GOMERY	
	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		100 CITS	TOWN OR LOCA	TION				
<u>E</u>	Maryland Montg	Omo * V		ver Spr				10d. INSIDE CITY LIMITS?	
	10s. STREET AND NUMBER	Omery	211		ING 1 K YES 2 D. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?				
FUNERAL	13502 Northgate Da				20906			ed States	
] E	11. MARITAL STATUS 12 1 Never Married 2 Married	FORCES? 1 YES	N U.S. ARMED	13. WAS DE	CENDENT OF HISPAI	IIC ORIGIN? (Specify Yes	or No — 1	I. RACE — American Indian, Black, White, atc.	
ВУ	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D			S 2 X NO Specif			Specify: Black	
	15. DECEDENT'S EDUCAT (Specify only highest grade con	ION npleted)	16e. DECEDENT'S	USUAL OCCUPAT	ION lost of working	16b. KIND OF BU	SINESS/INDU	STRY	
		College (1-4 or 5+)		ork done during m retired.)					
COMPLETED		2	Flight	Attenda		America		lines	
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Meiden			
BE	Dannie Maree					ree Bryan			
	19a, INFORMANT'S NAME (Type/Print)					Route Number, City or Tow			
-	Vivian Elaine Rice				ate Driv ϵ				
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	I from State cer	p.PLACE AND DATE Of the second	F DISPOSITION (A Cremat		DATE 20c. LO 3/5/93 Lau:		y or Town, Stata D	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE			ND ADDRESS OF FA		-		
	Ison a lua,	Mari	٠.			al Service		. D.C. 20012	
	23. PART I. Enter the diseeses, or com	pilcations that cause	d the death. Do n	ot enter the m	ode of dving, suc	Ave. IV.W.	wasn	t, Approximete	
	shock, or heart fellure. List iMMEDIATE CAUSE (Fine) disease or condition resulting in death) a	1.7		shote	vounds	of head	7	interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury		A CONSEQUENCE OF						
ERTIF	that initiated events resulting in death) LAST	DUE TO (OR AS /	A CONSEQUENCE OF	: 					
	PART II. Other significant conditions of	ontributing to deeth b	out not resulting in	the underlyin	o cause given in	Part I. 24a. WAS AN	ALITODEV	24b. WERE AUTOPSY FINDINGS	
DICAL				, are arraottyn	ag cause given in	PERFOR	IMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE	
						1 X YES 2	□ NO	OF DEATH?	
Σ						—		1 X YES 2 NO	
AN	25. WAS CASE REFERRED TO MEDICAL			26 P	LACE OF DEATH (Ch	ick only one)			
Sic		OSPITAL:		OTHER:		8 Other (Specify)			
PHYSICIAN: ME	27. MANNER OF DEATH	28a, DATE OF INJURY	28b. TIME	OF 28c. IN	JURY AT	8 ☐ Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCU	RED	
1 0, 1	1 Netural 5 Pending	03-03-199	IN.H	IRY W	ORK? YES 2 X NO	SUBJECT			
BY	2 Accident Investigation			The DIACE OF IN HIDY At home from the state of the state					
BY	2 Accident Investigation 3 Suicide 6 Could not be	28s. PLACE OF INJURY	— Al home, farm, st cify) HOME	reet, factory, offi		261. LOCATION (Street a City or Town, State) 13502 NO	RTHGA		
BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	HOME			13502 NO	RTHG	ATE DRIVE	
BY	2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN	28a. PLACE OF INJURY building, etc. (Special N: To the best of my know	HOME	f at the time, date	a and pleca, and due	1 3502 NO	RTHGA	ATE DRIVE	
COMPLETED BY	2 Accident 3 Sulcide 4 Memicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 0	28a. PLACE OF INJURY building, etc. (Special N: To the best of my know	HOME	f at the time, date	a and pleca, and due death occured at the	City or Town, State) 13502 NO to the cause(s) end mar time, data and place, an	RTHGA	ATE DRIVE	
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BALTIMORE, MARYLAND 21215-0020	rSIGIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should thin the State Dept, of Health and Mental Hygiene prior to bunial, cremation, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	THE HOST WILL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	THE PLANER CHIPECTOR: After this certificate has been signed by the attending physician and completely filled in by the formation, or removal.	ORTANT: Il item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR			ERTIF	TIL AND I	,_		I H		REG. NO			
	1. DECEOENT'S NAME (First, Middle, Last)			10/11		DEA		2. DATE	OF DEATH			3. TIME OF DEATH
	Mary Louise Bo	owden Hum	phrey						Mar	ch 5	, 19	93 YEAR	4:10 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	last birthday)	IF UNDE	R 1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH			NPLACE (State or Foreign
	216-46-9496	1 🗌 M 2XXF	79	YRS.	MONTHS	DAYS	HOURE	MIN.	Ap1	th, Day, Ybar)	913	Counti	n) lass.
	9a. FACILITY NAME (If not institution, give	street and number)			9b, CITY	r, town o	R LOCATION	ON OF DE				NTY OF D	
R	Bethesda Nursin	ng & Reti	rement	Ctn.	C	hevy	Cha	se	Montgomery				merv
DIRECTOR	RESIDENCE OF DECEDENT												
Ш	MD MOI					OR LOCAT							10d. INSIDE CITY LIMITS?
	1101	ntgomery		Ch	evy	Chas	e						1 XYES 2 NO
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FUNERAL							208					USA	
5	11. MARITAL STATUS 1 Never Married 2 Narried	12. WAS DECEDEN	T EVER IN U.SU	ARMED NO	13.	WAS DECI	ENDENT O	F HISPAN	NC ORIGI	N? (Specify Yas Rican, atc.)	or No-	14. RACE Black	E — American Indian, k, Whita, atc.
B	3 Widowed 4 Divorced	IF YES, GIVE Y	MAR OR DATES			1 TYES		Specify				Speci	tty:
	15. DECEDENT'S ED	UCATION	16a (DECEDENT'S	HEUAL O	COLIBATIO			Lan	VIND OF BUILD			White
	(Specify only highest grad Elementary/Secondary (0-12)	de completed)		(Give kind of life. Do NOT u	work done se retired.)	during mos	st of workin	g	164	. KIND OF BUS	INESS/INC	DUSTRY	
PL	Committee y/ Secondary (0-12)	College (1-4 or 5	*/	House						0	II.am.a		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)			nouse	WILC		18. MOTE	FR'S NAI	ME (First	Middle, Maiden	Home		
	Frank Chester I	Rowden				1				y Grav	,		
BE	19a. INFORMANT'S NAME (Type/Print)	30,000	-	19b. MAILING	ADDRES	S (Street ar				ber, City or Tow		Code	
5	Leonard G. Hum	ohrev								y Chas			0815
	20a. METHOD OF DISPOSITION		20b. PLAC	EANDDATE					DAT		CATION -		
	1 Buriel 2 Toremetion 3 Ret 4 Donation 5 Other (Specify)	moval from Stata	cametery, c	cremetory or o	thar placa)					1.0	exan	,	
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE	A	COMILO						ons, I		urra	• VA
	Marialla	05/2	. 1)1-							e,NW,W			- DC 20016
	23. PART I. Enter the diseasea, pr	complications the	Council the	donth Do									
	anock, or neart failure	List only one cau	ise on each ile	ne.	not enter	the mod	re or ayı	ng, sucr	n aa car	diac or reapi	ratory arr	eat,	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition	Pneumor	ni o										Onset and Death
	reaulting in death)		(OR AS A CONS	EOUENCE O	D.							_	2 months
_	_	Multip			r).								
호	Sequentially list conditions, if any, leading to immediate		(OR AS A CONS		F):								l year
8	cause. Enter UNDERLYING												
Ē	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONS	EOUENCE O	F):								
CERTIFICATION	resulting in death) LAST	that initiated events DUE TO (OR AS A CONSEQUENCE OF):								1			
		d											
	PART II. Other aignificant condition	d	death but not	resulting	In the un	el a el el a a		due a la l	David I				1
CAL	PART II. Other aignificant condition	d	death but not	reaulting	In the ur	nderlying	cause g	iven in i	Part i.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
EDICAL	PART II. Other significant condition	d	death but not	reaulting	In the ur	nderlying	cause g	iven in i	Part i.		MED?	24b.	
	PART II. Other aignificant conditio	d.	death but not	resulting	In the ur	nderlying	cause g	iven in i	Part i.	PERFOR	MED?	24b.	AMAILABLE PRIOR TO COMPLETION DF CAUSE
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31. DATE FILED (Month, Day, MAR 17

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. Fy

Julia Davidson Randalle

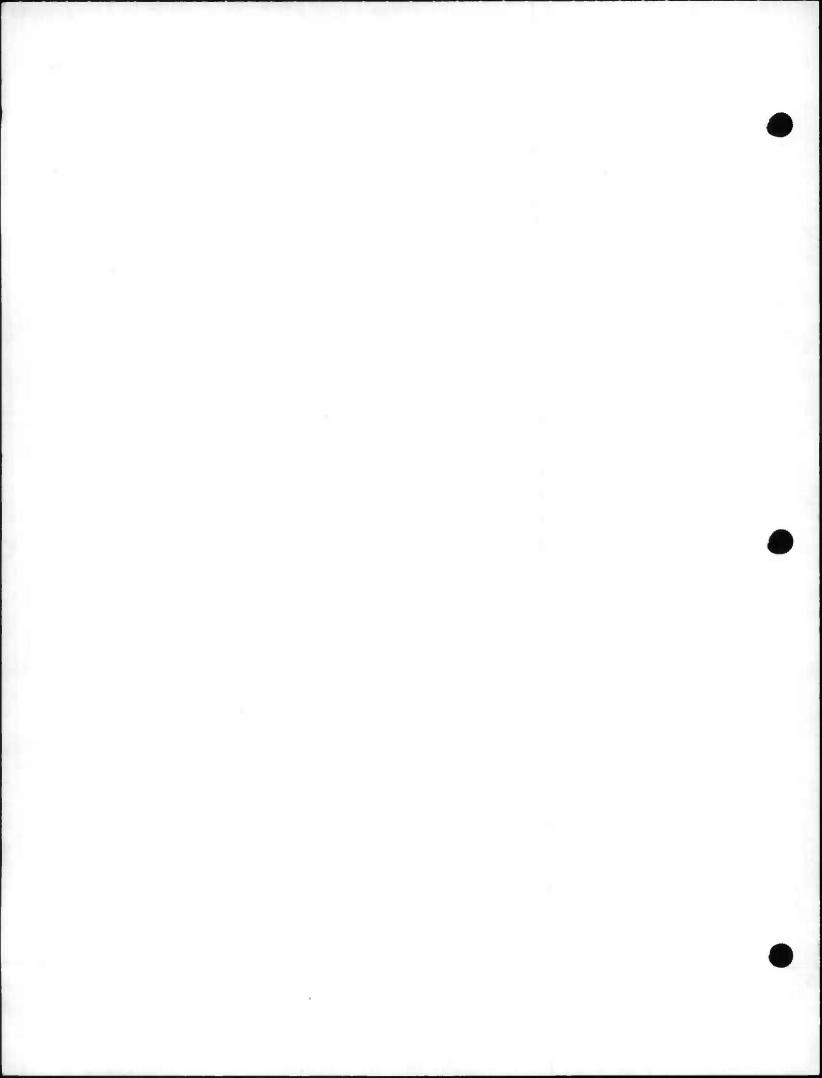
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N HO	particing. After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 3	noun me com with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

08793 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. OATE OF DEATH DAY 3. TIME OF DEATH YEAR William Luke Holt :42 p March 14. 1993 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 💹 M 2 🗌 F YRS. 84 1908 Washington D.C. July 6, 579-10-1422 9a. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF GEATH 9b. CITY, TOWN OR LOCATION OF GEATH DIRECTOR Howard County Hospital Columbia Howard RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 🗌 YES 2 💢 NO Maryland Kensington Montgomery 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 20895 United States 9720 Kensington Parkway 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Mexican, Puarto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES Specify: Specify: 8 3 🕅 Widowed 4 🗌 Divorced White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done life. Do NOT use retired.) Щ Elamentary/Secondery (0-12) College (1-4 or 5+) COMPL United States Government 4 Accountant 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) Not Available Not Available BE 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4. Bowlin Bay Court
Hilton Head South Carolina 29926 19a. INFORMANT'S NAME (Type/Print) Wilson Robert A.H. 20a, METHOO OF DISPOSITION
1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, State 4 Donation 5 Other (Specify) National Memorial Park Falls Church, Virginia 22 NAME AND ADDRESS OF FACILITY
ROBERT A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557
Avenue Bethesda, Maryland 20814 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wisconsin M00335 23. PART I. Enter the diseases, or complications that caused the december, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, **Approximata** Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition EMBOLISM 10 MIN PULMONARI ALUTB resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINOINGS MEDICAL PERFORMEO? AWAILABLE PRIOR TO DUODENUL MICER BLEEDING COMPLETION OF CAUSE 1 | YES 2 | NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: **EXAMINER?** OTHER: 1 | YES 2 | NO 4 - Nursing Home 5 - Residence 6 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, OESCRIBE HOW INJURY OCCURED 1 Waturel 5 Pending М 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide LETED 6 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. COMPI 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and memor as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 12en 3/14/93

2104

COLUMBIO MD



MARCH 13, 1993

3. TIME OF DEATH

7:15P

MARTIN ROCKWOOD HAVEN

24 hours after death. Page 6 may be retained by the hospital or attending physician. **BALTIMORE, MARYLAND 21215-0020** detached for 2 funeral director, page 5 should ysician and completely filled in by the prior to burial, cremation, or removal. the attending physician Mental Hygiene prior to

burial-transit permit, Pages 1, 2, 3 should

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OF VI	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2
5	OR

State

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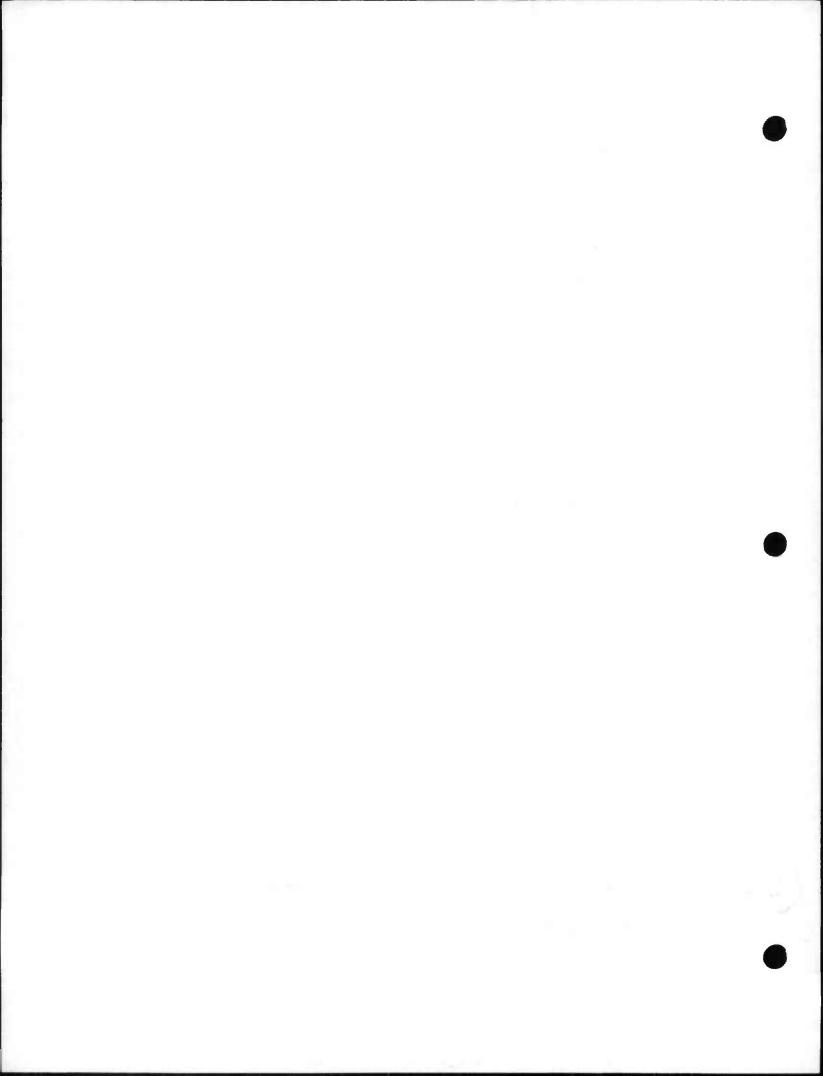
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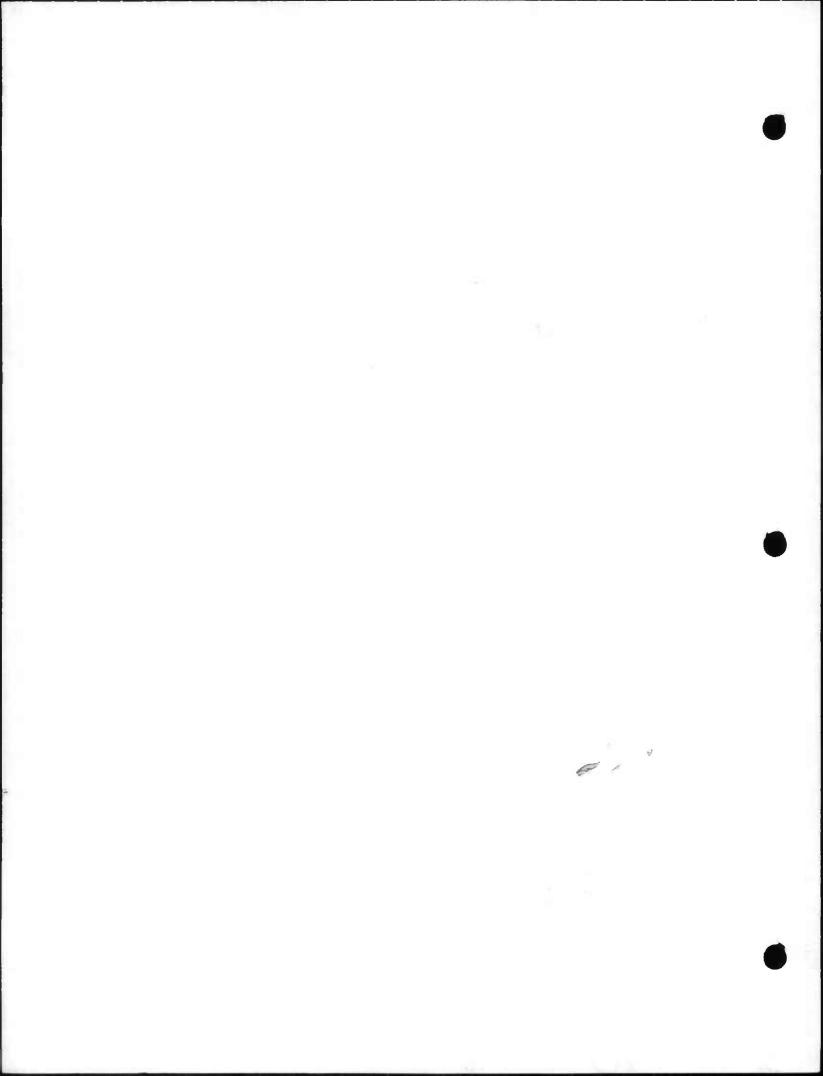
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign (Month, Day, Year)
JUNE 24, HOURS 1√2 M 2 □ F YRS. 217-44-0338 85 1907 MASSACHUSETTS 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ASBURY METHODIST HOME GAITHERSBURG MONTGOMERY RESIDENCE OF DECEDENT 10b. COUNTY 10c CITY TOWN OR LOCATION 10d, INSIDE CITY MARYLAND MONTGOMERY GAITHERSBURG 1 YES 2 NO 10s. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 211 RUSSELL AVENUE, #111 20877 UNITED STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 🔀 Widowed 4 🗌 Divorced WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 5+ ACCOUNTANT U.S. GOVERNMENT once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ CHARLES TAFT HAVEN LIZZIE ALLEN ROCKWOOD BE notified 19a. INFORMANT'S NAME (Typo/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ROY CHARLES HAVEN 15508 LANGSIDE STREET, SILVER SPRING, MD 20905 9 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must FORT LINCOLN CEMETERY 3/18/93 BRENTWOOD, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSE examiner 22. NAME AND ADDRESS OF FACILITY ROBERT A. PUMPHREY FUNERAL HOME/ROCKVILLE, INC. 300 WEST MONTGOMERY K0800M AVENUE, ROCKVILLE, MARYLAND 20850-2805 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between **Onset and Death** IMMEDIATE CAUSE (Final event, the disease or condition ardiovosas 26 Sagras resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS een signed by the Porte AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 YES 2 NO Car 1 YES 2 NO has been s Dept. of H PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA me 5 - Residence 6 - Other (Specify) the 50 27. MANNER-OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, INJURY 1 Netural 5 Pending 1 YES 2 NO BY After 2 Accident 26a. PLACE OF INJURY — At home, ferm, street, factory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 6 Could not be determined COMPLETED INERAL DIRECTOR: thin 72 hours after 28 4 Homlelde MPORTANT: If Item 29e. CERTIFIER THE CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) end manner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) H Det. Jo 46. MARCH 16, 1993 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN F. TAUBER, M.D. 8218 WISCONSIN AVENUE, BETHESDA, MARYLAND 20814 31. DATE FILED (Month 32 MEGISTRAN'S SIGNATURD PORTURES.

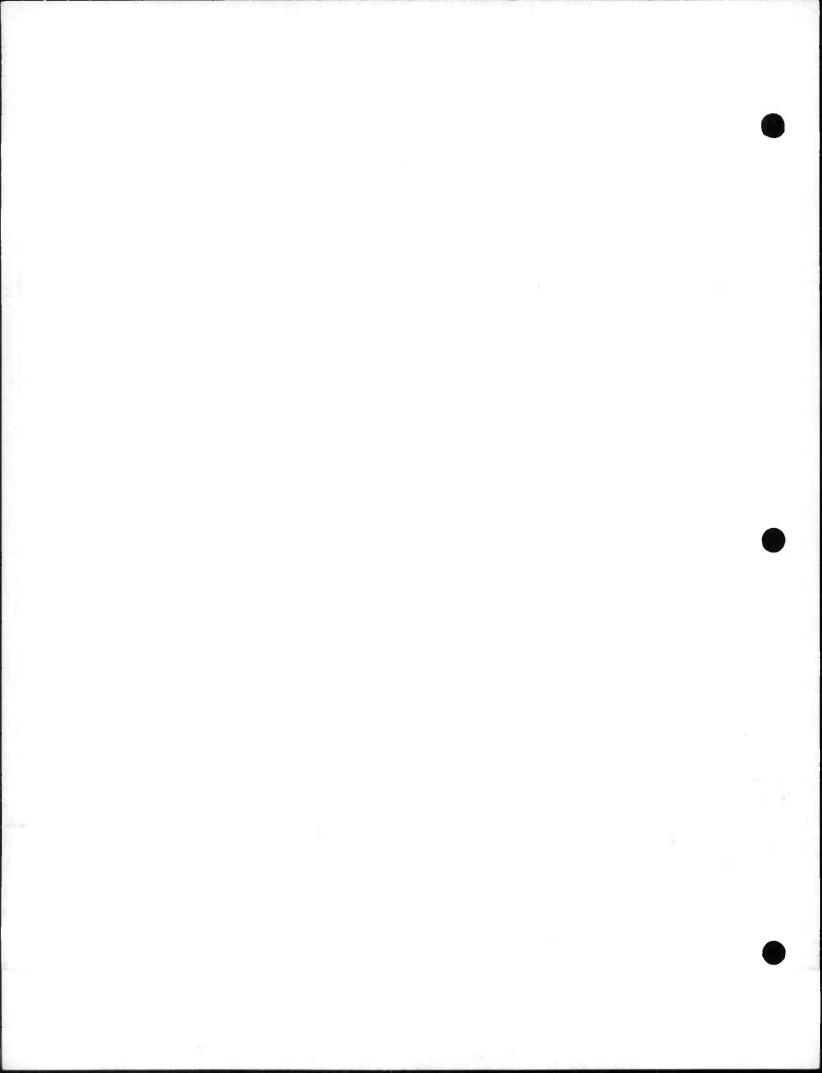


FOR STATE

					371L 1	OI L	JEAIH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Richard L	HAR	RIS						2. DATE OF DEATH MONTH DA MARCH 11	199	VEAR	5:18 A
	4. SOCIAL SECURITY NUMBER 219 88 2800	5. SEX 6. AC	3E (In yrs. last		IF UNDER 1 YE		IF UNDER 24 H	IRS.	7. DATE OF BIFITH APT 11 Year 3,	196	8. BIRTHPI 2 Country)	MD .
_	9a. FACILITY NAME (If not institution, give	street and number)		,	96. CITY, TOWN OR LOCATION OF DEATH 9c. CI			9c. COU	NTY OF DEA	тн		
TOR	Doctors Community	Hospital			Lanham Prince Georg				eorge			
DIRECTO	10a. STATE 10b. COUNT		2	101	CITY, TOWN OR LOCATION						Dd. INSIDE CITY LIMITS?	
AL D	MD. PRIN		5	BERW	YN E					to- CIT		YES 2 N
8	8427 58th AV				20740 U.S.A							
BY FUN	11. MARITAL STATUS XX Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 1 YOU IF YES, GIVE WAR OF	ES XXI		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 YES NO Specify: Specify:					- American Indian White, etc. WHI		
ETED	15. DECEDENT'S EDU (Specify only highest grade		16a. DE(CEDENT'S US ve kind of wor Do NOT use	SUAL OCCU	PATION ng most	of working		16b. KIND OF BUS	INESS/INC	DUSTRY	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		SHING					DELIVE	ZRV		
COMPL	17. FATHER'S NAME (FIRST, MIGHIN, LISS) CLARE NELE LE	E HARRIS	11220	7112110	,1011			NAM P	F (First, Middle, Maiden :		ARTID	
BE	CLAREDIE LE	E HARRIS)d	יזמכ	ILE V.	В	AKEK	
ō	19a. INFORMANT'S NAME (Type/Print) BONNIE HARRI	C	196					Rural Ro	ute Number, City or Town	, State, Zip	Code)	
	20s. METHOD OF DISPOSITION		20b. PLACE A	ND DATE OF		N (Name	e of		DATE 20c. LOC	CATION —	City or Town	, State
1	XSurial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	(George	e Wa	shin	igto	on Ce	em.	3/16/93	AD	ELPH	I, MD.
İ	21. SIGNATURE OF FUNERAL SERVICE LI	ICENSED 3	la			COMA		NER	AL HOME TON, D.C			RROLL
RTIFICATION	disease or condition resulting in death) a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. ANEMIA DUE TO (OR AS A CONSEQUENCE OF): c. NEPHROTIC SUNDROME DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
8	PART II Oh - I - III - III	d										
MEDICAL	PART II. Other algorificant condition SYSTEMIC III								PERFOR	MED?	C	ERE AUTOPSY FIN MAILABLE PRIOR TO OMPLETION OF CA F DEATH? YES 2 N
NAN:	25. WAS CASE REFERRED TO MEDICAL				2	6. PLAC	CE OF DEATH	H (Chec	k only one)			
YSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL:		DOA 4	THER:				Nother (Specify)	OME		
PH	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending		IY	DOA 4 28b. TIME (INJUR	OTHER: Nursing OF 286	Home	5 🗔 Reside	nce 6	4.4		CURED	
ED BY	EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/O	r) PRY — At hor	28b. TIME (OTHER: Nursing OF 286 TY M 1	Home INJUR WORK	5 Reside	nce 6	Other (Specify)	JURY OC		te Number,
ED BY PHY	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident	1 Inpettent 2 ER/O 28a. DATE OF INJUR (Month, Day, Yea 28e. PLACE OF INJUR	IRY — At hor pecify)	28b. TIME (INJUR	OTHER: Nursing OF 286 N 1 Det, factory, at the time,	Home INJUR WORK YES office	5 Reside TY AT TO S 2 NO	once 6	Other (Specify) House (Specify) House (Specify) House (Specify) House (Specify) House (Specify) House (Specify) House (Specify) House (Specify) House (Specify) House (House) House (Hou	nd Number	or Rural Rouled.	
BE COMPLETED BY PHY	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINI 29b. SIGNATURE AND TITLE OF CERTIFIE	28a. DATE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR (Month, Day, Yea 28a	IRY — At hor pecify)	28b. TIME (INJUR	OTHER: Nursing OF 286 N 1 Det, factory, at the time,	Home INJUR WORK YES offica data an	5 Reside TY AT (?? S 2 NC nd place, and th occured a	d due to	Other (Specify) House and DESCRIBE HOW IN 281. LOCATION (Street and City or Yown, State) the cause(s) and manume, data and place, and ER	nd Number ner se stat d due to th	or Rural Rouled. ted. te cause(a) a	nd manner as sta
BE COMPLETED BY PHY	EXAMINER? 1 VES 2 NO 27. MANMER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINI	28a. DATE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. PLACE	PRY — At hor pecify) wowledge, deal properties and/or in the period of	28b. TIME (INJUR ne, farm, stru ith occurred investigation,	OTHER: Nursing Nursing Off 1 2847 M 1 set, factory, in the time, in my opini	Home LINJUR WORK VES offica data an	5 Reside 77 AT 77 S 2 NC	d due to	Other (Specify) 28d. DESCRIBE HOW IN 28f. LOCATION (Street a. City or Town, State) the cause(s) and man me, data and place, and ER	nd Number	ted. The cause(a) a E SIGNED (N	nd menner as eta
ву рну	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIE	28a. DATE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR (Month, Day, Yea 28a. PLACE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. DATE OF INJUR (Month, Day, Yea 28a. PLACE	IPY — At horpodity) Overland the process of the pr	28b. TIME (INJUR ne, farm, stru ith occurred investigation,	OTHER: Nursing Nursing Off 1 2847 M 1 set, factory, in the time, in my opini	Home LINJUR WORK VES offica data an	5 Reside 77 AT 77 S 2 NC	d due to	Other (Specify) House and DESCRIBE HOW IN 281. LOCATION (Street and City or Yown, State) the cause(s) and manume, data and place, and ER	nd Number	ted. The cause(a) a E SIGNED (N	nd manner as sta



	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEP CERT	ARTMENT OF HEALTH AND IFICATE OF DEATH	MENTAL HYGIENE REG. NO.	33 08796
8	1. DECEDENT'S NAME (First, Middle, Last)	RAYMON HARRIS HAR		2. DATE OF DEATH MONTH DAY 3 - 14-	YEAR 3. TIME OF DEATH 93 8: 46 a., M
	4. SOCIAL SECURITY NUMBER 412 22 4606		MONTHS DAYS MOURE NO	Olerate Day March	8. BIRTHPLACE (State or Foreign Country) TENNESSEE
TOR	90. FACILITY NAME (If not institution, give sti Holy Cross Hosp		96. CITY, TOWN OR LOCATION OF SILVEY Spring		county of DEATH NONTGOMERY
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MO	4	CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	104. STREET AND NUMBER 10423 HUNTLEY AVE		101. ZIP CODE 20902	10g.	CITIZEN OF WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 11 YES 2 NO IF YES, GIVE WAR OR DATES			
LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	completed) (Give kind	T'S USUAL OCCUPATION of work done during most of working If use retired.)	16b. KIND OF BUSINESS	
COMPL	17. FATHER'S NAME (First, Middle, Last)	4 LUMBER		LUMBER DEAT	LERS ASSOCIATION
TO BE	CARL RIVERS HAR		BERDIE ING ADDRESS (Street and Number or Run	MAY POSTON al Route Number, City or Town, Stelle	e, Zip Code)
T T	DAVID H. HARRELL 200. METHOD OF DISPOSITION	20b. PLACE AND DA	AFTERNOON LANE TEOF DISPOSITION (Name of	COLUMBIA, MARY	YLAND 21045 N — City or Town, State
	1 Denrial 2 Cremation 3 Remo	METROPOL'I	CREMATORY 22. NAME AND ADDRESS OF	3/19 ALEXANI	DRIA, VIRGINIA
	Mark	tlell	FRANCIS J. C	COLLINS FUNERAL	L HOME, INC. IL.SPR.,MD.20901
RTIFICATION	shock, or heart failure. I	DUE TO YOU AS A CONSEQUENCE	e that for	when as cardiac or respiratory	Approximate Interval Between Onset and Death
N: MEDICAL CE	PART II. Other attrifficant conditions	contributing to death but not results	The finderlying cause given in the finderly given in the finderlying cause given in the finderlying cause given in the finderlying cause given in the finderlying cause given in the finderlying cause given in the finderlying cause given in the finderlying cause given in the finderlying cause given in the finderlying cause given in the finderlying cause given in the finderlying cause given in the finderlying cause given in the finderlying cause given in the finderlying cause given in the finderlying cause given in the finderlying given given given given given given given given given given given given given given gi	In Part I. 24e. WAS AN AUTOP PERFORMACY 1 YES 2 NO	AMALABLE PRIOR TO
YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	25. PLACE OF DEATH (
F	2T. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Moren, Doy, Year) 28b.	TIME OF SBL INJURY AT WORK? M 1 YES 2 NO	264. DESCRIBE HOW INJURY	OCCURED
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	38e. PLACE OF MUSERY — At home, family all foliating, etc. (Specify)	m, street, factory, office	26f. LOCATION (Street and Mur City or Town, State)	mber or Hurel Houte Number,
O BE COMPLETE	const. After a	TAN: To the beautiff my knowledge, death occ			
BE	290. SIGNASSING MOGTER OF GENTIFIER		эм. ысеняе н D 339		DATE SIGNED MINISTER MINISTER
10	HENRY X. INLE, 1	1.D. 8830 CAMERON S	PCCOVIDEOUS	ER SPRING, MAI	RYLAND 20910
	31. DATE FILED (Month, Day Year)	H. RIGISTRAR'S SIGNATURE			



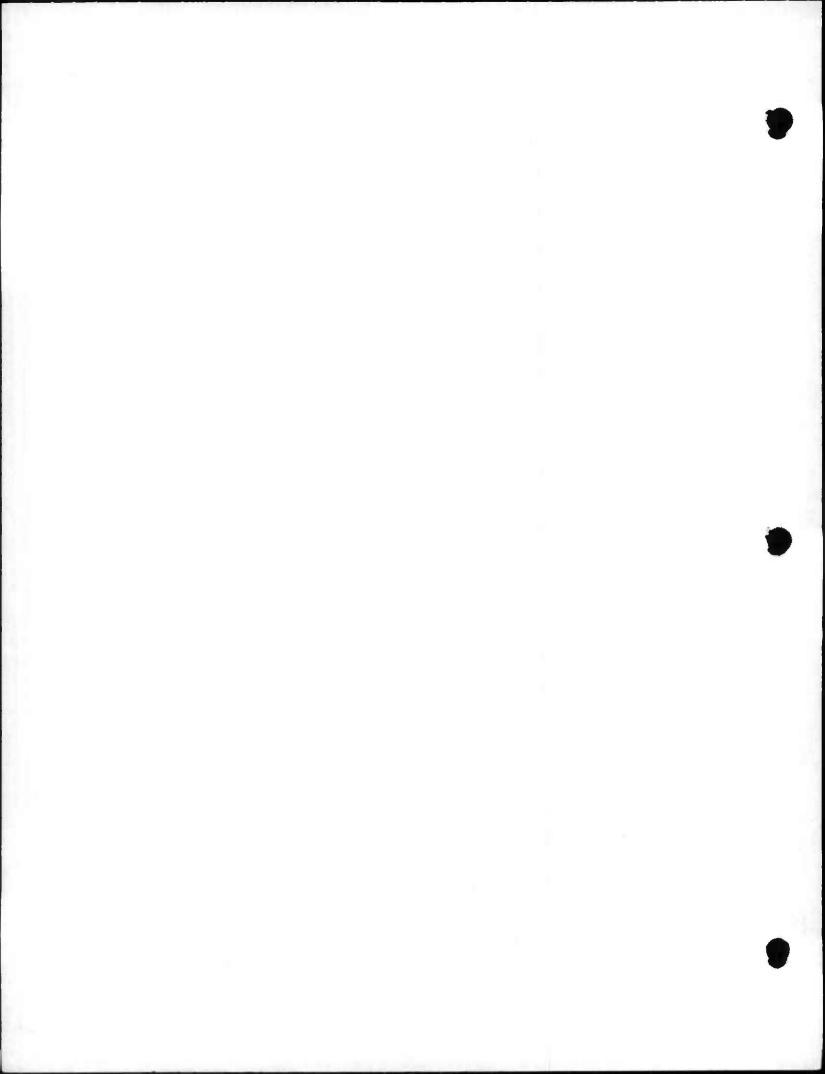
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

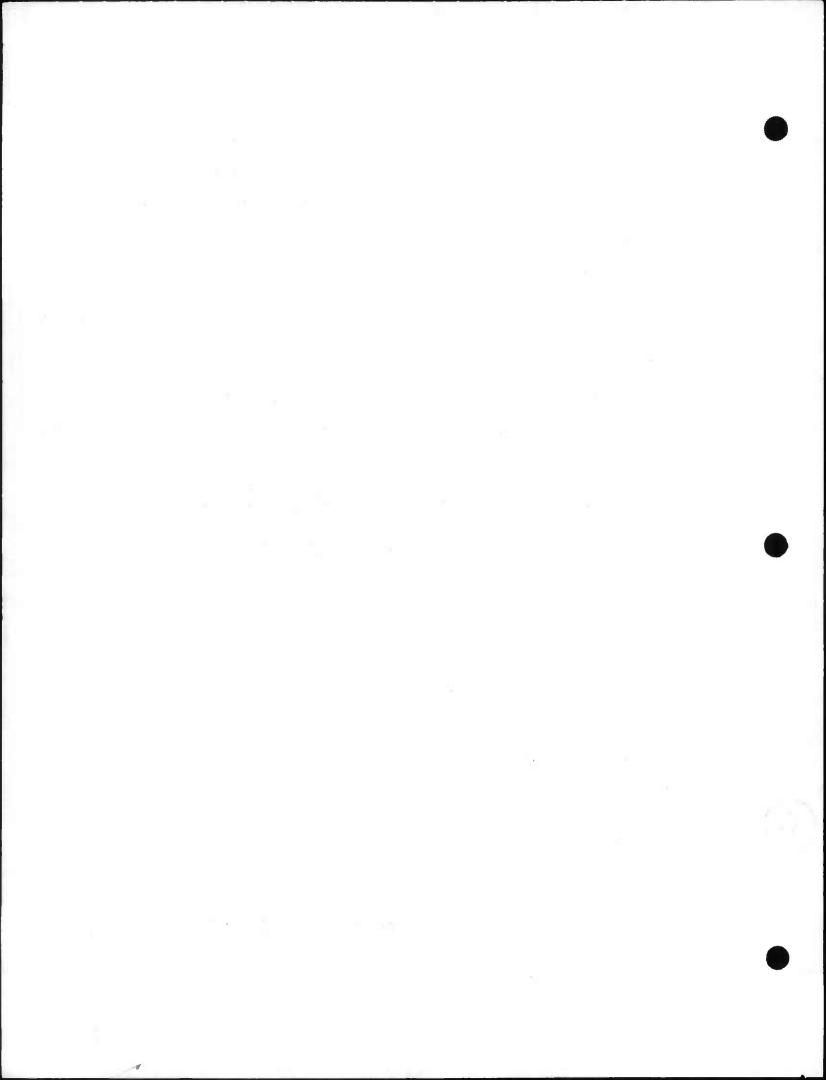
ical examiner must be notified at once.	IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
moval.	be fied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
by the funeral director, page 5 should be detached for use as	TO THE WARAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as
after death. Page 6 may be retained by the hospital or atten	TO WE HOSPITE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or atten
DALLIMONE, MARILAND ZIZI	Le constant de la con

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	1 - FOR STATE (OF MARYLAND / DEPARTM CERTIFIC			NTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	CECILE G. HUNGER	RFORD		DATE OF DEATH		3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX	88 YRS. MO	UNDER 1 YEAR NTHS DAYS	HOURS MIN.	DATE OF BIRTH (Month, Day, Year)); - 16 - 0 3	8. BIRT Coun	HPLACE (State or Foreign Irv)
TOR	9a. FACILITY NAME (If not institution, give street and number that I will street and number that it is a street and number that it is a street and number that it is a street and number that is a str	" Carriage "	CITY, TOWN OF	Ver Sp	ก่าง	9c. COUNTY OF	Somen
100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION MD Montgomey SILVER SPRING							
FUNERAL	106. STREET AND NUMBER 515 THAYER AVENUE			ZIP CODE 20910		10g. CITIZEN OF	WHAT COUNTRY?
B	11. MARITAL STATUS 12. WAS DEC	EDENT EVER IN U.S. ARMED 1 ☐ YES 2 ☑ NO IVE WAR OR DATES	If yes, spec	NDENT OF HISPANIC Colly Cuben, Mexican, Pt	or No- 14. RAC Blac Spec	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
COMPLETED	INESS/INDUSTRY						
	17. FATHER'S NAME (First, Middle, Lest) EDWARD GOODRICH	TEACHER		18. MOTHER'S NAME (First, Middle, Meiden S WADE	Surname)	
TO BE	198. INFORMANT'S NAME (Type/Print) ANN GARVIN (DAUGH			AD OAKHAN	Number, City or Town		10168
	20a. METHOD OF DISPOSITION Dariel 2 Cremation 3 Removal from State Donalion 5 Other (Specify)	20b. PLACE AND DATE OF D	SPOSITION (Nam	eof	OATE 20c. LOC	T MORRIS	own, State
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	~	FRANCIS	ADDRESS OF FACILITY S J. COLLI	INS FUNER		INC.
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	E TO (OR AS A CONSEQUENCE OF): E TO (OR AS A CONSEQUENCE OF): E TO (OR AS A CONSEQUENCE OF):	A	Lenoca	areino		interval Between Onset and Death SEVELAL In a 1-24VS
PHYSICIAN: MEDICAL CE	PART II, Other aignificant conditiona contribution	g to death but not resulting in the	ne underlying	cause given in Pari	24s. WAS AN A PERFORM	AED?	D. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetient		HER:	CE OF DEATH (Check of			
	27. MANNER OF DEATH 28s. DAT (Mo.	E OF INJURY 26b. TIME OF INJURY	28c. INJUI		1. OESCRIBE HOW IN	JURY OCCURED	
TED BY	3 Suicide a Court 28s. PLA	CE OF INJURY — At home, ferm, streeding, etc. (Specify)	t, factory, office	281	. LOCATION (Street ar City or Town, State)	nd Number or Rural	Route Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the built one) 2 MEDICAL EXAMINER: On the beater						s) and manner es stated.
O BE	296. SIGNATURE AND TITLE OF CERTIFIER	Golf, Mit		29c. LICENSE NUMBER		29d. DATE SIGNED	(Month, Day, Year) LIG1 199.3
=	30. NAME AND ADDRESS OF PERSON WHO COMPLETED G. Lehnard Goldin	CAUSE OF DEATH (ITEM 27) (Typo, Pric	139ro			Spr	ND
	31. DATE FILEO (Month, Day, Year) MAR 18 93	STRAR'S SIGNATURE					



			FOR 1 STATE	STATE OF I	MARYLAN	D / DEPAR	TMENT OF	HEALTH	I AND M	IENTAL HYGIEN		U	3 1 3 0
			REGISTRAR))))))			RVEY	F DEA	TH	REG. NO		WEAD 3.	. TIME OF DEATH
			4. SOCIAL SECURITY NUMBER	RVEYMA	7	s. last birthday)				303-13			0638 M
	plr		341-46-9620	1 🗆 M 🍇 🔭 F	65		IF UNDER 1 YEAR	's HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year) 11-03-1	927	Country) MISS	ACE (State or Foreign
-	2, 3 should	Shady Grove Adventist Hospital Rockville MON RESIDENCE OF DECEDENT 100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION									TY OF DEAT		
	Pages 1,											10	Dd. INSIDE CITY
	permit. F		Maryland N	Montgome	ry		Rockv	111E	Ne .		Tue- outre		YES 2 NO
· ·	Sig	FUNERAL	12630 Viers Mi	ll Road				101. 211 000	208	353	log. Critiza	U.S.	
BALTIMORE, MARYLAND 21215-0020	as the burial-transit	B	11. MARITAL STATUS Marital 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDER FORCES? IF YES, GIVE Y	YES 2	NO	If yes,	DECENDENT specify Cub YES 25 NO	en, Mexican,	C ORIGIN? (Specify Ye, Puerto Rican, etc.)	s or No— 1	4. RACE — Black, W Specify:	American Indian, White, etc. Black
1218	nse	ETED	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)	164	Give kind of v	USUAL OCCUP	ATION most of work	ing	16b. KIND OF BU	ISINESS/INDU	STRY	
Z OZ	ched for	COMPLE	Elementary/Secondary (0-12) 6th	College (1-4 or 5	+)	Dome							
YLA	5 should be detached for notified at once.	ш	17. FATHER'S NAME (First, Middle, Last) ? Williams	5				18. MOT		E (First, Middle, Meiden n Gordon			
MAR	5 should notified	TO B	190. INFORMANT'S NAME (Type/Print) Otis C. Harvey	/ (Frien	a)	196. MAILING	ADDRESS (Stre	et end Numbe	or or Rural Ro	oute Number, City or Tow	vn, State, Zip C	iode)	MD 20853
BALTIMORE, I	or, page		20s. METHOD OF DISPOSITION DEPOSITION Comparison 2 Greenation 3 Green		20b. PLA	CE AND DATE	F DISPOSITION	(Name of		DATE 20c. LC	CATION — C	ty or Town.	State
IMO	al direct		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE /	_ Har	mony		IAL E		3/19 La	naove	er, r	MD
BAL1	d in by the funeral director, page or removal.		168048 K	/sno	wdl	u	RO	CKVII	LLE,	NERAL HO MD 208	50		
24 hours aft	or re		23. PART i. Enter the diseases, or shock, or heart fellure IMMEDIATE CAUSE (Finel	complicatione that. List only one cer	ise on eech	line.					iretory arre	et,	Approximate interval Between Open and Death
			disease or condition resulting in death)	S. DUE TO		YOCAY	dial L	Intai	retic	on 			Oneet and Death
OX 68760,	and con burial,	NO	Sequentially list conditions,	b		ISEQUENCE OF							
	anding physician and c Hygiene prior to buria or other traumatic	ICAT	if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	C									
S, P.O. B(al Hygien or oth	ERTIFICATION	that initiated events resulting in death) LAST	d	(OH AS A COP	ISEOUENCE OF):						
	y the att of Menta injury,	AL C	PART II. Other eignificent condition	one contributing to	deeth but n	ot resulting i	n the underly	Ing ceuee	given in P	art I. 24a. WAS AN			ERE AUTOPSY FINDINGS
OF VITAL RECORD PHYSICIAN: The law requires that the	has been signed by the attending physician Dept. of Health and Mental Hygiene prior to n 23 shows any injury, or other traun	MEDICAL	2	enul fai	whe,	D 4821	es Ma	Merci	3	PERFOI		OF	MRABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
AL.	cate has b State Dept.	NAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26.	PLACE OF D	DEATH (Chec	k only one)			
OF VITAL	certificate I the State I, or Item	PHYSICIAN:	1 YES 2 NO	HOSPITAL:						Other (Specify)			
N OF		ВУ РН	1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF (Month, D	lay, Year)	28b. TIMI INJI	M 1	INJURY AT WORK? YES 2	- 1	28d. DEŞCRIBE HOW I	INJURY OCCU	RED	
CE	DIRECTOR: A hours after de item 28 is		3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE 0 building,	F INJURY — A etc. (Specify)	I home, ferm, s	treet, factory, of	ffice	:	281. LOCATION (Street City or Town, State)		Rural Route	e Number,
HOSPITAL OF	₹2 =	COMPLETED	299. CERTIFIER (Check only one) 1 CERTIFYING PHYS 2 MEDICAL EXAMIN										nd menner es stated.
IH.		띪	296. SIGNATURE AND TITLE OF CERTIFIE	roy Here					ENSE NUMB				onth, Day, Year)
2	-0=	5	30. NAME AND ADDRESS OF PERSON W	HECHT M			Print)		_	WHEATON, I	-	2906	
•			31. DATE FILED (Month, Day, Yber) MAR 1 7 93	32. SEGISTRA	B'S SIGNATUR	Andree							
													DHMH.16 Rev 1/89



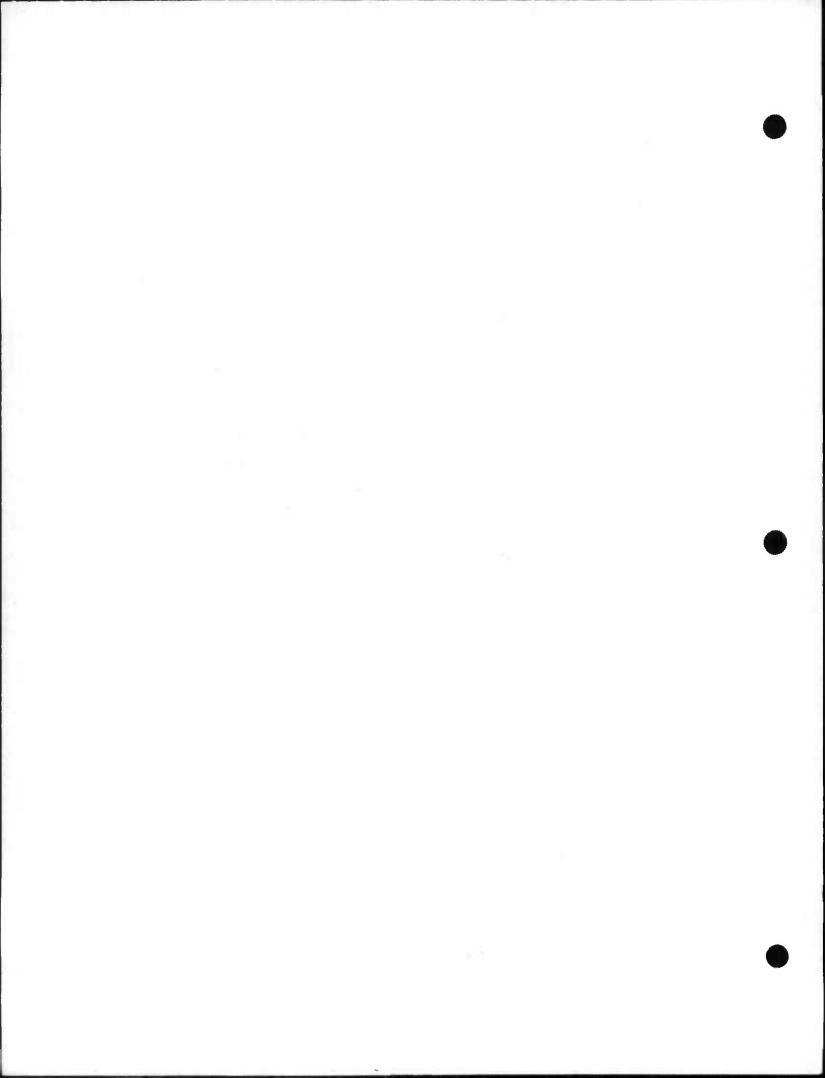
DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Ha YEAR 7:42 RESMA 93 03 08 AM 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS 1 🛛 M 2 🗌 F 1925 PA 224-24-3691 68 Jan. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR tospita Sha C CO1 Rockville Montgomery RESIDENCE OF DECEDEN 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Gaithersburg 1 🔀 YES 2 🗌 NO permit. FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? detached for use as the burial-transit 425B N. Frederick Ave. Apt. #6 20877 U.S.A. 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

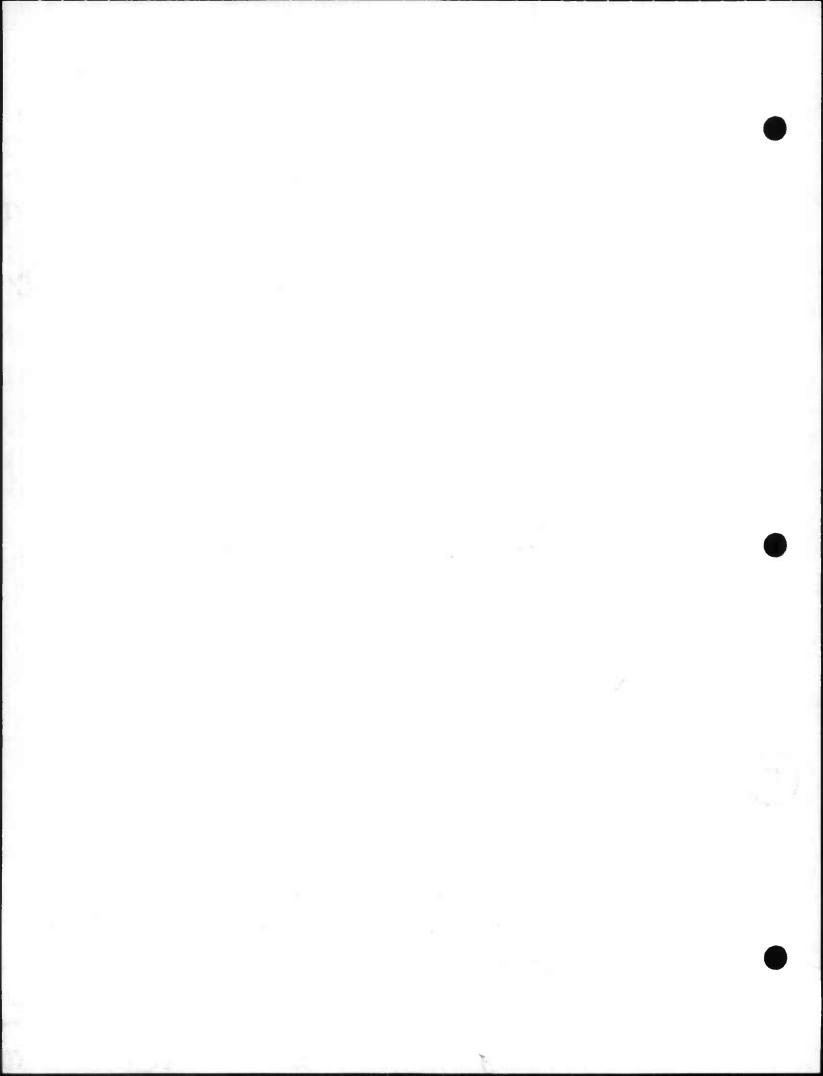
1 YES 2 X NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced 1943 to 1946 White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 White House Guard Executive Protective Services once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) funeral director, page 5 should be James Aaron Hartley BE Helen Bailey 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Joan E. Jensen 19342 Churubusco Ln., Germantown, MD 20874 Pe 20a. METHOD OF DISPOSITION
1 ☒ Buriel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must Gate of Heaven Cemetery 3/11/93 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 the or removal event, the medical 23. PART i. Enter the diseasea, or complications that caused the deeth. Do not enter the mode of dying, auch as cardiec or reapiratory arrest, the attending physician and completely filled in by Mental Hygiene prior to bunal, cremation, or remo Approximate ehock, or heart feliure. List only one cause on each line. intervei Betwe IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) THE MACONSTOLENCE OF): Atherocleratic Heart Disease traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART ii. Other aignificent conditions contributing to death but not resulting in the underlying ceues given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the PERFORMED? AVAILABLE PRIOR TO Disease any COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO 1 YES 2 NO PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem the State HOSPITAL: OTHER: 1 YES 2 NO ne 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY r this c marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigat 1 YES 2 NO death death В 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 69 3 Suicide 6 Could not be 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED DIRECTOR: hours after 28 4 Homicide 29e. CERTIFIER
(Check only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated. TO THE HOSPICAL OF TO THE WITHOUT DE FILED WITHIN 72 HO IMPORTANT: If its 2 ___ MEDICAL_EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER D/P6/229d. DATE SIGNED (Month, Day, Year) BE 76ta 13-8-93 MA 5 A-ROTS 2TAIN, Md . 10401 old Peogletown Rd. Betherde Md 20814 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 09 93 Julia Davidson Rondell



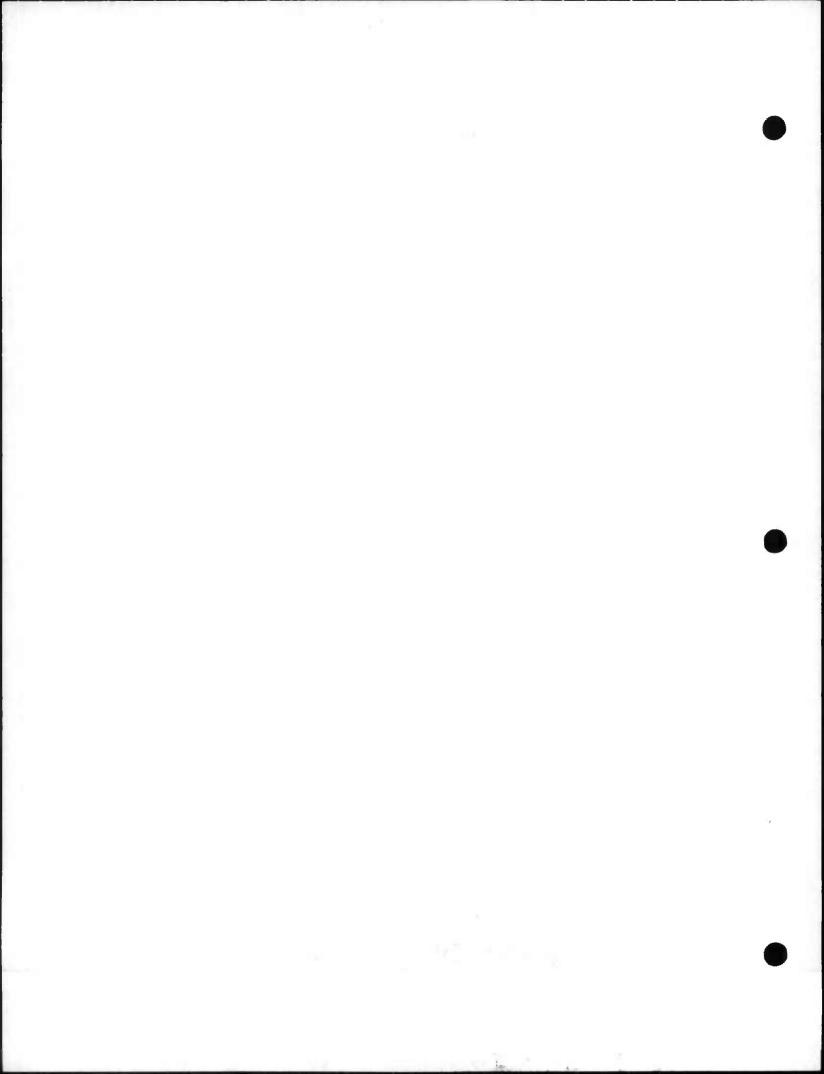
BALTIMORE, MARYLAND 21215-0020

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last		2. DATE OF DEATH MONTH DA		3. TIME OF DEATH				
	The section of the se	Robert John				MARCH 7.	1993	1:10 A M	
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year)	8. BIRT Cour	THPLACE (State or Foreign nitry)	
	138 16 6207 9a. FACILITY NAME (If not institution, give	1 ☑ M 2 □ F	70 YRS.			Aug. 29 1	1101	w Jersey	
Œ	DOCTORS COMMUNI			LANHAI	IN OR LOCATION OF DE		9c. COUNTY OF	EOORGE 'S	
18	RESIDENCE OF DECEDENT								
DIRECTOR	10a. STATE 10b. COUN		565.00	ITY, TOWN OR LO	CATION			10d. INSIDE CITY	
	Maryland Prin	nce George's	Вс	owie				1/1 YES 2 □ NO	
RA	6912 Hillmeade F	₹₫.			10f. ZIP CODE 20720		WHAT COUNTRY?		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARMED	12 WAS	DECENDENT OF NISPAN	IC ODICING Seconds Visc	d States		
	1 Never Married 2 KMarried	FORCES? 1 XXE	ES 2 NO	If yes	, specify Cuban, Mexican YES 2 NO Specify	, Puerto Rican, etc.)	Bla	CE — American Indian, ick, White, etc.	
BY	3 Widowed 4 Divorced				TES 2 MIC Specify	No	эре	White	
COMPLETED	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)	(Give kind o	S USUAL OCCUP I work done during	ATION most of working	16b. KIND OF BUS	SINESS/INDUSTRY		
1 5	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Flooty			1	1 06		
NO.	17. FATHER'S NAME (First, Middle, Last)		FIECUI	icial 3	Superintend	Tent Loca		V	
	George B. Heimr	ich				oeth Young	,		
TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	IG ADDRESS (Str	et end Number or Rural R				
	Betty Jane Heimr	ich	691	2 Hilln	neade Rd. I	Bowie Md.	20720		
	20a. METHOD OF DISPOSITION 1 20 Disposition 3 Rec	movel from State	20b. PLACE AND DATE	E OF DISPOSITION	(Name of	DATE 20c. LO	CATION — City or	Town, State	
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L		Maryland		ns Cemeter		n <u>eltenha</u>	am, Md.	
	D.1 1 6	6	D.	Bea	11-Evans I	Funeral Ho			
_	Danni -	Com	Ina	160	00 Annapol	lis Rd. Bo	wie Md.	20715	
	23. PART I. Enter the diseases, or shock, or heart fellure	complications that cause on List only one cause on	sed the death. Do n each line.	not enter the	mode of dying, such	ss cardiac or respi	ratory erreat,	Approximate Interval Between	
	IMMEDIATE CAUSE (Final disease or condition	Time		50	~T	no	•	Onset and Death	
	resulting in death)	DUE TO (OR A	S A CONSEQUENCE	0F):	ghe !	11 cmil	And	40 03	
z		ASQ.	nallo	~		V)		İ	
	Sequentially list conditions, if any, leeding to immediate	DUE TO (OR A	A CONSEQUENCE	OF):					
2	Cause. Enter UNDERLYING CAUSE (Disease or injury	C. DUE TO /OR A	S A CONSEQUENCE	OD.					
CERTIFICATION	that initiated events resulting in death) LAST	DOE TO (ON A	S A CONSEQUENCE	OFJ:					
		d							
¥	PART II. Other significant condition	ons contributing to death	h but not resulting	In the underl	ying cause given in i	Part I. 24a. WAS AN PERFOR		Ib. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO	
MEDIC	V (VA	10.50	3/11.	1	<i></i>	1 _ YES 2	₽.HO	OF DEATH?	
×	1. 14	aurins	1			_		1 YES 2 NO	
3									
	25. WAS CASE REFERRED TO MEDICAL			26	PLACE OF DEATH /Cho	ck anh ane)			
SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	Autpetient 3 DOA	OTHER:	PLACE OF DEATN (Che				
HYSIC!	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN	1 Inpetient 2 ER/O	Y 28b. Ti	OTHER: 4 Nursing i	fome 5 Residence		NJURY OCCURED		
3Y PHYSICIAN:	EXAMINER?	1 Inpatient 2 ER/O 28a. DATE OF INJUR (Month, Day, Year	Y 28b. Ti	OTHER: 4 Nursing I	fome 5 - Residence	6 Other (Specify)	NJURY OCCURED		
B	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	1 Impatient 2 ER/O 28e. DATE OF INJUR (Month, Day, Year)	ty 28b. Ti	OTHER: 4 Nursing I ME OF JURY M 1	fome 5 Residence (INJURY AT WORK?	6 Other (Specify)		l Route Number,	
B	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be datermined	28a. DATE OF INJUR (Month, Day, Yea) 28a. PLACE OF INJUR building, stc. (S)	IRY — At home, farm, pecify)	OTHER: 4 Nursing I ME OF LJURY M 1 , street, factory, c	fome 5 Residence (INJURY AT WORK? YES 2 NO	5 Other (Specify) 28d. DESCRIBE NOW II 28f. LOCATION (Street a City or Town, State)	ind Number or Flural	l Route Number,	
B	EXAMINER? 1 YES 2 NO 27. MANNER GEDEATN 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only)	28e. DATE OF INJUR (Month, Dey, Year 28e. PLACE OF INJUR	TY r) 28b. Ti IR IRY — At home, farm, pecify)	OTHER: 4 Nursing I ME OF	fome 5 Residence (INJURY AT WORK? YES 2 NO office	5 Other (Specify) 28d. DE\$CRIBE NOW II 28f. LOCATION (Street a City or Town, State)	ind Number or Rural		
E COMPLETED BY	EXAMINER? 1 YES 2 NO 27. MANNER GEDEATN 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only)	28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJUR building, stc. (S) SICIAN: To the best of my kn IER: On the basis of examina	TY r) 28b. Ti IR IRY — At home, farm, pecify)	OTHER: 4 Nursing I ME OF	fome 5 Residence (INJURY AT WORK? YES 2 NO office	5 Other (Specify) 28d. DESCRIBE NOW II 28d. LOCATION (Street a City or Town, State) to the cause(e) and man	and Number or Flural mer as stated, d due to the cause		
BE COMPLETED BY	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 2 Accident 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMIN	28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJUR 28a. PLACE OF INJUR building, atc. (S) SICIAN: To the beat of my kn IER: On the beat of examina	IRY — At home, farm, pecify) Overlage, death occur, titlon and/or investigat	OTHER: 4 Nursing I ME OF LUURY M 1 , street, factory, c	fome 5 Residence (INJURY AT WORK? YES 2 NO Modern Residence (Injury Residenc	5 Other (Specify) 28d. DESCRIBE NOW II 28d. LOCATION (Street a City or Town, State) to the cause(e) and man	and Number or Flural mer as stated, d due to the cause	r(a) and manner as stated.	
E COMPLETED BY	EXAMINER? 1 YES 2 MO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON W	28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJUR 28a. PLACE OF INJUR building, atc. (S) SICIAN: To the beat of my kn IER: On the beat of examina	IRY — At home, farm, pecify) Overlage, death occur, titlon and/or investigat	OTHER: 4 Nursing I ME OF LUURY M 1 , street, factory, c	fome 5 Residence (INJURY AT WORK? YES 2 NO Office In, death occured at the I 29c. LICENSE NUM	5 Other (Specify) 28d. DESCRIBE NOW II 28d. LOCATION (Street a City or Town, State) to the cause(e) and man	and Number or Flural mer as stated, d due to the cause	r(a) and manner as stated.	
BE COMPLETED BY	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 2 Accident 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMIN	28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJUR 28a. PLACE OF INJUR building, atc. (S) SICIAN: To the beat of my kn IER: On the beat of examina	ITY 28b. TI IN 1979 At home, farm, pocify) At home, farm, f	OTHER: 4 Nursing I ME OF 28c. JURY M 1 , street, factory, common in my opinion, in my op	fome 5 Residence (INJURY AT WORK? YES 2 NO Office In, death occured at the I 29c. LICENSE NUM	5 Other (Specify) 28d. DESCRIBE NOW II 28d. LOCATION (Street a City or Town, State) to the cause(e) and man	and Number or Flural mer as stated, d due to the cause	r(a) and manner as stated.	



	This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		
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physician	burial-tra		
or attending physic	se as the		
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by the ho	be detac		at once
retained	5 should		notified
6 may be	ctor, page		nust be
ith. Page	neral dire		miner n
s after de	by the fu	emoval.	dical ex
IYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician	y filled in	ith the Sun Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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be execu	iclan and	ior to bur	raumati
certificate	ding phys	lygiene pr	other t
he death	the atten	Mental H	njury, or
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	FOR STATE REGISTRAR		STATE OF I	MARYLAI					EALTH DEA		MENTAL	HYGIEN REG. NO	93	0.8	1088
	1. DECEDENT'S NAME (FIRST AMBRODE	A		HREI	iN						2. DATE OF MONTH	D/		JEAR 93	3. TIME OF DEATH M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS.									Day, Year)		Country			
1	212 10 14/0 1 K M 2 F 84														
E	The second of th														
18	RESIDENCE OF DECEDENT Crofton Anne Arundel									rundel					
DIRECTOR	106. STATE 106. COUNTY 106. CITY, TOWN OR LOCATION 106. INSIDE CITY LIMITS?														
	TAXES I I III														
FUNERAL	3611 Majest	ic La	ne					-		715					States
3	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN L	U.S. ARMED)	13. 1	WAS DEC	ENDENT (OF HISPAN	IIC ORIGIN?	(Specify Yes		14. RACE	- American Indian, White, etc.
BY	1 Never Married 222 3 Widowed 4 Dive	Sarvied	IF YES, GIVE							Specif	n, Puerto Ric V: NO	an, etc.)	- 1	Specif	y:
		CEDENT'S EDU		1	16a. DECED	ENT'S U	SUAL OC	CCUPATIO	N N			IND OF BUS	SINESS/INC	MISTRY	White
E	(Specify on Elementary/Secondary (I	ly highest gradi 0-12)	completed) College (1-4 or 5		(Give ki	ind of wo NOT use	retired.)	during mo	st of worki	ng	i cen			33.00	
COMPLETED			2		Sale	es M	lana	ger			F	Refin	ing δ	Sme	lting
	17. FATHER'S NAME (First, M										ME (First, Mic		,		
H	Joseph G. H		ln		105.84	*** ***	000000				eth H				
2	Elizabeth A		nev						.c La		Route Number	e Md.		0715	
	20a. METHOD OF DISPOSIT	TION		20b. P	LACE AND	DATEOF	DISPOS	ITION (Ne	me of		DATE	-		City or Tox	vn, State
	4 Donation 5 Other		noval from State	_ cemete Ho	Ty Re	edee	er plece) emer	Cen	eter	У		Ва	altim	ore 1	Md.
	21. SIGNATURE OF FUNERA	L SERVICE LI	CENSEE	(22. I	NAME AN	EVA	SS OF FA	duny Junera				
	Howen	C.	CVan	2 1.	res	ノ.	1	6000	Ann	apo1	is Rd	. Boy	vie M	d. 20	0715
	23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	eart failure.	a. G	t saused to	th line.	Ca	M	the mo	de of dy	ing, suc	h ss cardla	c or respi	ratory an	rest,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Inju- that initiated events resulting in death) LAS	diate ING Iry	с	(OR AS A C											
PHYSICIAN: MEDICAL (PART II. Other significa	not condition	ns contributing to	1	t not resul		the un	derlying) Cause	given in		4a. WAS AN PERFOR	IMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
S	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:				OTHER		ACE OF D	EATH (Ch	eck only one)				
HYS	1 YES 2 NO		1 Inpetient 2				Nun			esidence	6 Other (N II III OO	OURER	
		Pending Investigation	(Month, E		1.0	INJU	RY M	WO	RK?	□ NO	28d. DESCI	HIBC FIOW I	NJUHY OC	CUHED	
TED BY	2 Deutstein	Could not be determined	26e. PLACE C building,	OF INJURY — etc. (Specify,	At home, i	farm, str	eet, facto	ory, office			28f. LOCAT City or	ION (Street a Town, State)	and Number	or Rural R	oute Number,
COMPLETED			ICIAN: To the best of a												and menner ee stated.
I w	296. SIGNATURE AND TITLE	OF CENTINE	M 4 /							ENSE NU			29d, DAT	E SIGNED	1 1
TO B	Hurs!	U th	1/h						0	35	485) -	7/4	3/3/93
	30. HAME AND ADDRESS OF	ard)	K Schal	BE OF DEAT	H (ITEM 27)	(Type, P	Print)								
	MAR 0 9 199	3	32. REGISTRA	ur's signation—Ran		Î	4								



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NOING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 ma	After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Vernon Hess 1993 March 9:37 Рм 5. SEX 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) HOURS 1 M 2 - F 136-32-5756 YRS. 72 3 - 6 - 20New Jersey Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Malcolm Grow USAF Medical Center Andrews AFB Md 20331-5300 Prince George's RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Oberwalluff, Germany 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit Vitusberg II 6229 <u>United</u> States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 ☐ NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuben, Maxican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 - YES 2 NO BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) ommisary/Distribution Civil Service 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) te Frederick Hess BE Veronica Chew notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Brendenwood Drive, Apt. A204 2 Fred Hess Voorhees N.J. 08043 9 29a. METHOD OF DISPOSITION
1 ☐ Burlel 2 ☑ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must 4 Donation 5 Other (Specify) Crematory 3-8-93 Clinton.Md examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Minno Clinton.Maryland 20735 or removal medicai 23. PART (. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory errest, Approximate shock, or heart feliure. List only one ceuse on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death the cremation, diseese or condition resulting in death) a. Cardiorespiratory Failure of unknown Etiology or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): of Health and Mental Hygiene prior to burial CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST item 23 shows any injury, PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 X NO 1 YES 2 NO BY PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) the State HOSPITAL:
1 Dispetient 2 ER/Outpetient 3 DOA OTHER: 1 TES 2 NO me 5 Rasidence 8 Other (Specify) 6 TO THE HOSPITAL OR ATTENDING PHYSICIA TO THE FUNERAL DISECTOR: After this cert be filed within 72 pours after cleath with the IMPORTANT: If Hern 2E is marked, or 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER

1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the films, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) March 3, 1993 2

ISS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

TRAN'S SIGNATURE Randall

Daniel Coverdell, Captain, USAF, MC

MAR 0 9 1993

Andrews AFB MD 20331-5300

Malcolm Grow USAF Medical Center

pital or attending physician. ad for use as the burial-transit permit. Pages 1, 2, 3 should

BALTIMORE, MARYLAND 21215-0020

SION OF VITAL RECORDS, P.O. BOX 68760,

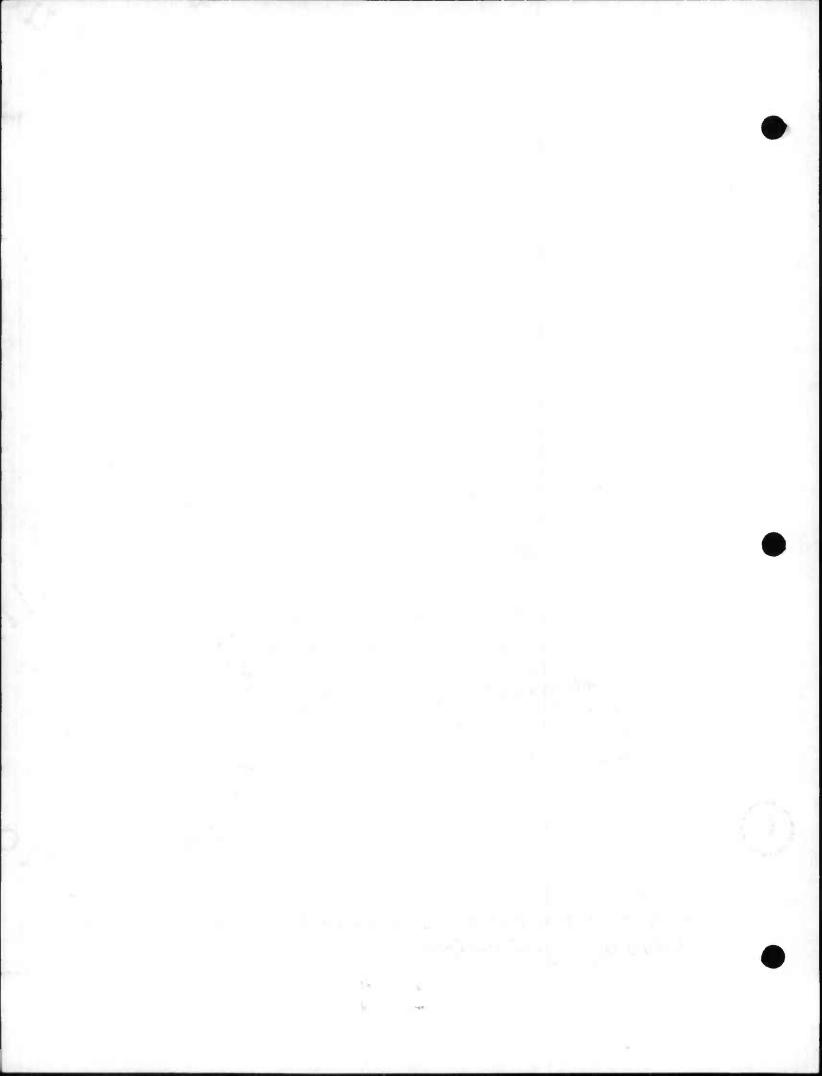
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TO THE HOSPINE, OF MILES MG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital	TO THE FINE PARTIES. WHEN THIS CENTIFICATE has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to the filled in by the funeral director, page 5 should be detached to the filled in the filled to the filled in the filled to the filled in the filled to the fil	IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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30. NAME AND ADDRESS OF PERSON WHO COM PAUL A. DE VORE 31. DAYE FILED (Month, Day, Year) MAR 0 9 1993 June

MD 4203 6/C 32. REGISTRAR'S SIGNATURE a Davidson-Randolle

												C	13	08803
	1 - FOR STATE REGISTRAR	STATE OF M			TMENT				MENT		GIEN G. NO.	E	, ,	0000
	1. DECEDENT'S NAME (First, Middle, Last)				<u> </u>				2. DAT	E OF DE			YEAR	3. TIME OF DEATH
	THELMA		HANCOCK								28		93	2 30A M
1 1	4. SOCIAL SECURITY NUMBER	5. SEX	AND THE PARTY OF T							E OF BIF	TH		B. BIRTH	IPLACE (State or Foreign
	244 14 6368	1 M 2 KF	M 2 XF 75 YRS. MONTHS DAYS HOURS MIN.						(Month, Day, Year) Country) 1 1 5 18 N.C.					
	9a. FACILITY NAME (If not institution, give str	set and number)								1.7	10	9c. COU	NTY OF D	
<u>۳</u>	F PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PR									PRIN	ICE G	E0RGE'S		
15	RESIDENCE OF DECEDENT													
#	PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION MD PG SEAT PLEASANT										10d. INSIDE CITY LIMITS?			
	MD P	PG		S	EAT	PLE	CASA	NT						1 KYES 2 NO
A	10e. STREET AND NUMBER					101.	ZIP CODE	Ε	_			10g. CIT	IZEN OF V	WHAT COUNTRY?
FUNERAL	7000 GREIG COU	RT Apt	#103			20	743						USA	
3	11. MARITAL STATUS	12. WAS DECÊDENT	EVER IN U.S. AR		13. V	WAS DECE	ENDENT O	F HISPAN	IIC ORIG	IN? (Spe	cify Yes	1	14. RACE	- American Indian,
1	1 Never Married 2 Married	IF YES, GIVE W	☐ YES 2 🔯 N AR OR DATES	10			2 JNO			o Rican,	etc.)		Speci	k, White, etc.
ВУ	3 Wildowed 4 Divorced						X	,						Black
ETED.	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	16a. DE	CEDENT'S	USUAL OC	CUPATIO	N of workin	-	10	Sb. KIND	OF BUS	SINESS/INI	DUSTRY	
iii	Elementary/Secondary (0-12)	Coflege (1-4 or 5+)	- Man	Do NOT u	se retired.)	uring mos	H OF WORKE	y						
AP.	9		P:	racc	Pr					Sc	old	ier	SH	ome
COMPL	17. FATHER'S NAME (First, Middle, Last)			And the Control of th	-		18. MOTH	IER'S NA	ME (First	, Middle,	Maiden	Sumame)		
ш	THOMAS CHAPL	IN						LOH	TSA	NN	HAI	RRIS	TON	
0	19a. INFORMANT'S NAME (Type/Print)		191	. MAILING	ADDRESS	(Street ar		-						
2	CHRISTINE WHI	ጥፑ	63		1st									77/2
	20a. METHOD OF DISPOSITION		20b. PLACE	NDDATE	OF DISPOSI	TION (Ner	ne of D	ATT	0 04	TE	20c. I O	CATION	City or To	wn State
	1 Burial 25 Cremation 3 Remo	val from State	cemetery, cre WASH	matory or o	ther place)	אים כדי	MTO.	DA VPT	T NC	"	TAT	דים כוז	MT	wit, Stata
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSE	IMAZUI	MGI			D ADDRES			•	LAU	JKEL	MD	•
	ND 6	10,11	101.				NS			LH	OMI	Ξ		
ш	7.200	Tough.					HUN							
	23. PART I. Enter the diseases, or co shock, or heart fallure. L	omplications that	caused tha de	ath. Do i	not entar	the mod	de of dyl	ng, suc	h as ca	rdiac o	r respi	ratory an	rest,	Approximate
	IMMEDIATE CAUSE (Final	ist only one ceus	e on each line											Onset and Death
		metal	20/17. A	451	1265									
	reaulting in death) a	Metal.	OR AS A CONSEC	DUENCE O	F):									
-		A 4	10000	18	. 0	10								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	Acute DUE TO (OR AS A CONSEC	UENCE O	F):	46								
¥	cause. Enter UNDERLYING	Diale	over 14	011	in	1		,						
트	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSEC	UENCE O	F):		rue				Α.			
토	resulting in death) LAST	ANT	MOSC	len	obe	CAN	dias	11111	cul	11	D-	100	10	
빙														
4	PART II. Other significant conditions	contributing to	death but not n	esulting	In the un	darlying	cause g	given in	Part I.		MAS AN	AUTOPSY	24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDICAL	Stevens Johns	y syre	lione	,	en.	Vil					YES 2	4.4		COMPLETION OF CAUSE OF DEATH?
	Al sure de	rondon	1. The	LIM	ulor	er X	Mac	med				7		0. 00
2	Carpylone	· A	10	A.		7	-	7	_					1 TES 27 NO
M	25. WAS CASE REFERRED TO MEDICAL	7,11	ve-nu		_	26. PL	ACE OF D	FATH (Ch	ack nak	one)		-		
PHYSICIAN:	EXAMINER?	HOSPITAL:	ER/Outpetlent 3	□ no.	OTHER	1:								
×	27. MANNER OF DEATH	28s. DATE OF		26b. TIM		ing Home 28c. INJU	5 Re	sidence		_		WIEW OO	OURER	
	1 Natural 5 Pending	(Month, De			URY	WOF	RK7	144	28d. U	EŞCHIBE	HOW II	NJURY OC	CURED	
B	2 Accident Investigation	20- 21-05-01	* IA I II I I I I I I I I I I I I I I I				ES 2	NO						
8	3 Suicide 6 Could not be	building, o	INJURY — At house. (Specify)	me, term,	street, facto	ory, office			261. LO	y or Town	(Street and state)	ind Number	r or Rural F	Route Number,
E														
4	29a. CERTIFIER (Check only	IAN: To the best of r	my knowledge, de	ath occurr	ed at the til	me, data	and place,	and due	to the c	ause(s) :	end man	ner as sta	ted.	
COMPLETED	one) 2 MEDICAL EXAMINER	: On the basis of ax	amination and/or i	nvestigatio	on, in my o _l	olnion, de	ath occur	ed at the	time, da	te and p	lace, an	d due to th	ne cause(a) and menner as stated.
EC	296 SIGNATURE AND TITLE OF CERTIFIER	0					29c. LICE	NSE NUM	/BER			29d. DAT	E SIGNED	(Month, Day, Year)
0	Buller Velo	elm					1	211	95	2				8-93
일	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH (ITEM	4 27) /Xmm	Dring)		7	J - 0	, ,				a.	3 7 3

Hy attrille MD 20181



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DIVISION OF VITAL RECORDS, P.O. BOX	THADING PHYSICIAN: The law requires that the death certificate be execu
VISION	ATTENDING
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	1 - FOR STATE REGISTRAR		STATE OF I	MARYLAND C	DEPAR						HYGIEN REG. NO	_			
	1. DECEDENT'S NAME (First,					-					DATE OF DEATH			3. TIME	OF DEATH
	CARRIE JEAN HOLLAND									MARC		AY 1993	YEAR	J :	30 PM M
	4. SOCIAL SECURITY NUMBER 5. SEX		5. SEX	6. AGE (In yrs. le	st birthday)	_	ER 1 YEAR	IF UNDER		7. DATE OF BIRTH					State or Foreign
- 8	215–46–3333		1 ☐ M 2 💢 F	78	YRS.	MONTHS	DAYS	HOURS	MIN.	March March	1 4,	1915	Wes	št V	irginia
	9a. FACILITY NAME (If not institution, give street end number)						TY, TOWN D								
O.	DOCTORS CO	ITAL	LANHAM-SEABROOK						PRIN	CE G	EORG	GE'S CO.			
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY				10c, CITY, TOWN OR LOCATION								City on		
	Maryland Prince George's				New Carrollton								LIR	SIDE CITY AITS?	
	10e. STREET AND NUMBER		3002 90		1,0,	101. ZIP CODE						I too CITI	ZEN OF W		ES 2 NO
2	7604 Vicar	Street			20784							S.A.		ON THE P	
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. A	RMED	13	. WAS DEC						14, RACE — American Indian.		
	1 Never Married 2 💢		FORCES? 1	YES XX			If yes, spe	elfy Cubs	m, Mexica	n, Puerto Ric			Black	k, White,	etc.
B	3 Widowed 4 Divor	ced		0	TES 1 YES 2 TYNO Specify				r.			Specify: White			
日日	15. DECE (Specify only	DENT'S EDUC	CATION completed)	16a. D	ECEDENT'S	NT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY									
쁘	Elementary/Secondary (0-		College (1-4 or 5	+)	(Give kind of work done during most of working life. Do NOT use retired.) Cafeteria Staff				Duval High School						
COMPLETED	NOT AVAILABI		T AVAILA	BLE Ca	recer	Id						SCIIC	~		
BE CC	17. FATHER'S NAME (First, Mic Fleetwood 1		y Mullin	S							E (First, Middle, Meiden Surneme) Mae Ritchy				
TO E	19a INFORMANT'S NAME (Type/Print) James B. Holland				196. MAILIND ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 7604 Vicar Street, New Carrollton, Maryland 2078						20784				
	1XX Buriel 2 Cremation 3 Removal from State cameter				ACEANDDATEDFDISPOSITION (Name of y, crematory or other place) Lincoln Cemetery 3-10-			OATE 20c. LOCATION — City or Town, State							
	21. SIGNATURE OF FUNERAL SERVICE LICENSES				Linco	22	NAME AN	D ADDRE	SS OF FA	CHITY	N ITY			Land	
	· JAA Macrin				Rendon/Hale Lanham Funeral Home 9013 Annapolis Rd., Lanham, Marylane deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,					and	20706				
	23. PART I. Enter the dis	enges, or o	complications that	t caused the d	eeth. Do i	not ente	er the mo	de of dy	ing, suc	h aa cardla	c or resp	iratory em	est,		pproximata terval Between
	IMMEDIATE AUSE (Final									nset and Death					
	disease or condition resulting in death) a. CARDID - PULMONARY ARREST DUE TO (OR AS A CONSCOURNCE OF):														
No.	Sequentially list conditions, DUE TO (DR AS A CONSEDUENCE OF): DUE TO (DR AS A CONSEDUENCE OF):														
CERTIFICATION	If any, leeding to immediate cause. Enter UNDERLYING COLONARY HEART DISEASE ATHERDS (STATHERDS) (STATHERDS)									/ 178m					
윤	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events COLONARY HEART DISEASE ATHEROSCIETIOSIS GENERALIZED DUE TO (OR AS A CONSEQUENCE OF):									50					
듄	resulting In death) LAST DIABETES MELLITUS														
S															
ÄL	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? AMAILABLE P								UTOPSY FINDINGS LE PRIOR TO						
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M	1 TES 2 NO									S 2 NO					
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PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO EXAMINER?	MEOICAL	HOSPITAL:			OTHE		ACE OF D	EATH (Ch	eck only one)					
IYS	1 YES 2XXND 1 N Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)														
	27. MANNER OF OEATH 1 Netural 5 Pending 28a. OATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY AT WORK?			7.00	28d. OESCRIBE HOW INJURY OCCUREO						
В	2 Accident Investigation 28s. PLACE OF INJURY			F INJURY — AL h	M 1 YES 2 NO Al home, farm, street, factory, office										
ETED	4 Homicide determined building, etc. (Specify)					rome, sellii, stieet, tectory, office			281, LOCATION (Street and Number or Rural Route Number, City or Town, State)						
COMPLETED			CIAN: To the best of R: On the basis of e) and me	nner ee stated.
ш	29b. SIGNATURE AND TITLE	OF CERTIFIER				-		29c, LICI	ENSE NUN	MBER		29d. DAT	E SIGNED	(Month,	
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a	Benjer	. HID				
30. NAME	AND ADDRESS	OF PERSON WHO	COMPLETED	CAUSE OF	DEATH (ITEM 27) (Type, Prin	nt)

29c. LICENSE NUMBER 0 2 5 9 2 5

29d. DATE SIGNED (Month, Day, Year)

MULG, 1993

7720 WISCONSIN AVE J.M. BERGER MD #205, 31. DATE FILEDINGS OF DESCRIPTION 32. BEGISTRANS SIGNATURE andell

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10)	TO THE HOSPITA	TO THE FUNERAL	be filed within 72 h

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	DEC NO

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)	. /	/1		2. DATE OF DEATH MONTH DA	Y YE	3. TIME OF DEATN			
	ELIZABITH	V.	H	INRY	03 /		3 1:13 PM			
	4. SOCIAL SECURITY NUMBER 229-05-4489	5. SEX 6. A		F UNDER 1 YEAR IF UNDER 24 HRS. ONTHE DAYS HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) 2-10-1917	1 0	NRTHPLACE (State or Foreign Sountry) rginia			
OR	98. FACILITY NAME (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL CLINTON PROPERTY OF DEATH PROPERTY									
	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d.									
L DIRECTOR	Maryland Prince George's			per Marlboro		LIMIT 1 - YES				
PA PA	9115 Marlboro Pi	1	101. ZIP CODE	OF WHAT COUNTRY?						
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN ILS ARMED			20772 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No.— 14			USA			
	1 Never Married 2 Married FORCES? 1 YES 2 NO			If yes, specify Cuban, Mexical 1 ☐ YES 2 ☑ NO Specific S		14. RACE — American Indian, Black, Whita, atc.				
В К	3 X Widowed 4 Divorced			· · · · · · · · · · · · · · · · · · ·	ту.	Specify:				
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S US (Give kind of wor	SUAL OCCUPATION k done during most of working etimed.)	16b. KIND OF BUS	SINESS/INDUST	RY			
) E	Elementary/Secondary (0-12)	College (1-4 or 5+)								
MC	17. FATNER'S NAME (First, Middle, Last)		ISwitchboa	ard Operator	Feder:		ernment			
		v Wilt		18. MOTNER'S N		-				
BE	19a. INFORMANT'S NAME (Type/Print)	A MIII	19b, MAJLING A	DDRESS (Street and Number or Rura	Maude Mumber City or Town	Helesle	e)			
5	Peggy J. Schmid	t		entworth Dr. (
	20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF	DISPOSITION (Name of	DATE 20c. LOC					
	1 M Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	11012 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	rt. Linco	In Cemetery 3	-13-93 Brei	ntwood.	Maryland			
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home							
	►UM FINIEN			6160 Over 1	Malas runera	al Home	e L, Md. 20745			
	23. PART I. Entar the diseases, or	complications that cau	sed tha death. Do not	antar the mode of dying, au	ch as cardiac or respir	on nill	Approximata			
	ahock, or haert fellure. List only one cause on each line. Interval Batwe IMMEDIATE CAUSE (Final									
	disease or condition									
N	Sequentlelly list conditions, Due to OR AS A CONSEQUENCE OF:									
CERTIFICATION	If any, leading to immediate cause, Enter UNDERLYING	DUE TO (OR A	S A CONSEQUENCE OF):							
윤	CAUSE (Disease or Injury that Initiated events	c. DUE TO (OR A	S A CONSEQUENCE OF):							
Ē	resulting in death) LAST	302 10 (0.1.)	is a concedence or j.							
빙	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS									
¥.	PART II. Other significant condition	is contributing to deati	h but not resulting in	the undarlying cause given in	Perfori		24b. WERE AUTOPSY FINDINGS			
[음 [PREU MO NIA	4		1 _ YES 2		COMPLETION OF CAUSE OF DEATH?				
뿔		HERRY FOIL				1 TES 2 NO				
ä	MULTIPLE SCHENSIS									
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PLACE OF DEATH (C	theck only one)					
IXS	1 YES 2 NO	1 Nipotiont 2 ER/O	Autpatient 3 DOA 4	☐ Nursing Home 8 ☐ Residence						
	1 Natural 5 Pending	(Month, Day, Yea		Y WORK?	28d. DESCRIBE HOW IN	IJURY OCCURE	D			
À	2 Accident Investigation 3 Suicide 8 Could not be	M 1 YES 2 NO	204 00471011 (0)	OCATION (Co						
	3 Suicide 8 Could not be detarmined Carried Barried Suicide 8 Could not be detarmined Carried Barried Suicide									
2	29a. CERTIFIER 1 CERTIFYING PHYSICIAN, TO ID- hard of the land of									
COMPLET	(Check only one) CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
	ADE CICHATUR AND TITLE OF OFFICERS									
BE	men Ll	Uner 1	29c. LICENSE NUMBER 29d. OAT			E SIGNEO (Month, Day, Year)				
30. NAME AND ADDIESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Describ										
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph P. Caruso, M.D.									
	MAR 1 1 1993 Such Davidson-Mandell									

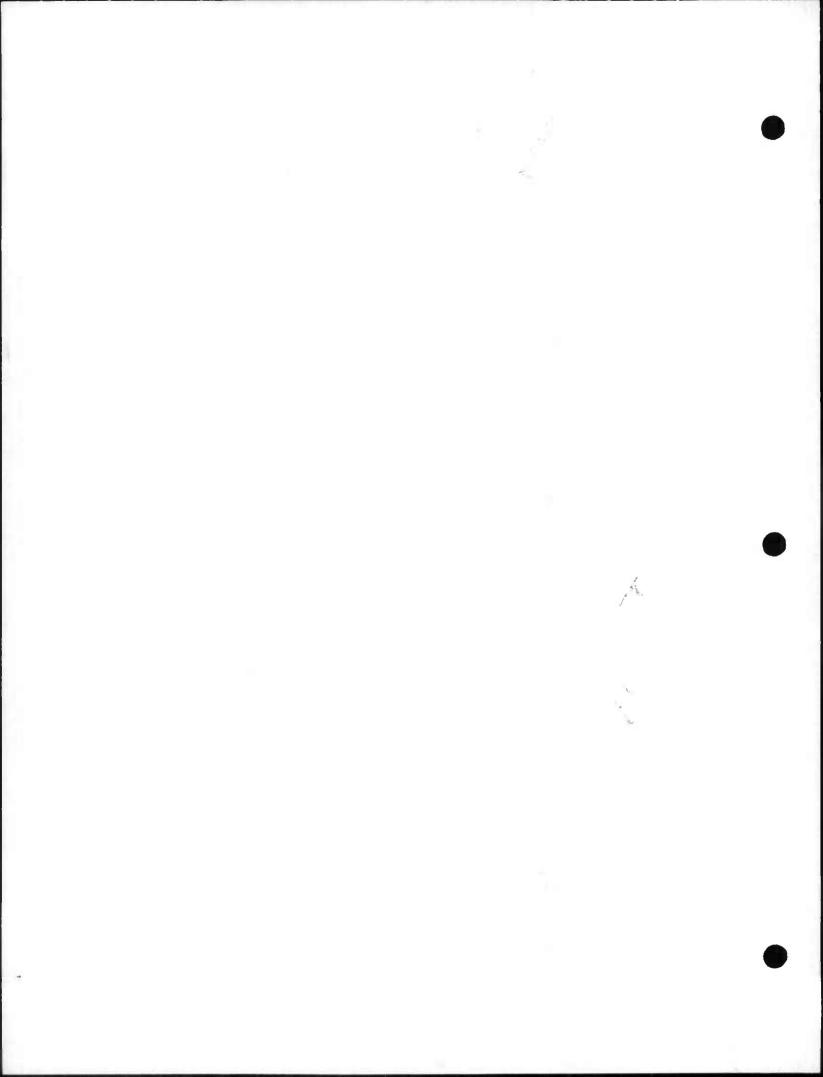
REG. NO

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

2. DATE OF DEATH 3. TIME OF DEATH YEAR Robert Compton HAMILTON 6:26 P February 993 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 VM 2 F 362-16-8004 23, 1919 Ohio use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9c. COUNTY OF DEATH DIRECTOR 11 County General Hospital Carroll Westminster 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Libertytown Frederick 1 TYES 2 NO FUNERAL 10f. 7IP CODE 10g, CITIZEN OF WHAT COUNTRY? 12114 Main Street 21762 U.S.A. 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or if yes, specify Cuban, Mexican, Puerto Rican, etc.)
 U YES 2 [Y NO Specify: 14. RACE — American Indian, Black, White, stc. FORCES? 1 YES 2 NO 1 Never Married 2 Marrie BY 3 Widowed 4 Divorced World War TT White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest gr Q Elementary/Secondary (0-12) College (1-4 or 5+) page 5 should be detached 6 Engineering Designer Electrical Engineer 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Harry G. Hamilton notified at Eulalia Compton BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Phyllis R Box 127 Libertytown Hamilton 0 Md pe 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State director, must 2-25-93 Smithsburg Crematory Smithsburg, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY funeral Keeney & Basford P.A. Funeral Home Allan M00703 the f 106 East Church St.. Frederick. 21701 medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. completely filled in by Approximate intarvai Betwe 6 **IMMEDIATE CAUSE (Final** Onset and Death or other traumatic event, the disease or condition May resulting in death) executed within DUE TO (OR AS A CONSEDUENCE OF) Hygiene prior to burial, - AU 2 9 CERTIFICATION been signed by the attending physician and it, of Health and Mental Hygiene prior to bun Sequentially list conditions, DUE TO (OR AS A CONSEDUENCE OF): if any, leading to immediate cause. Enter UNDERLYING HOPPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be 1 (Afree novae CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY shows any 1 TYES 2 THO 1 YES 2 NO has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Hem DIRECTOR: After this certificate hours after death with the State HOSPITAL: OTHER: 1 YES 2 NO ng Home 5 Residence 8 Other (Specify) Inpatient 2 - ER/Outpatient 3 - DOA 10 4 Nursi 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending investigation BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, lerm, street, factory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 100 COMPLETED 8 Could not be item 28 4 Homicide 29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. TO THE HOPPITAL O MPORTANT: 11 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, to the cause(e) and manner as stated. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Mornin, Day, Ye)
2 12 4 173 BE 9 DS 609 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph Ashwal M.D., 56 Thomas Johnson Drive, Frederick, 31. DATE FILED (Month, Day, Year)
FEB Z ± 32. REGISTRAR'S SIGNATURE 1278 gune our work-pandell

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



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RECOR	And in second
SION OF VITAL RECORDS, P.O. B	The second party of the second
OF VITAI	SAME AND
ÖZ	2000
SIO	CALCULATION OF
2	-

w requires that the death certificate be executed within 🚾 hours after death. Page 6 may be retained by the hospital or attending physician.	CONTROLLE After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be to state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ten 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
Death	e attend fental H	ury, or
nat the	and N	my in
ednires :	en signer	hows a
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N: Ine	State State	Item
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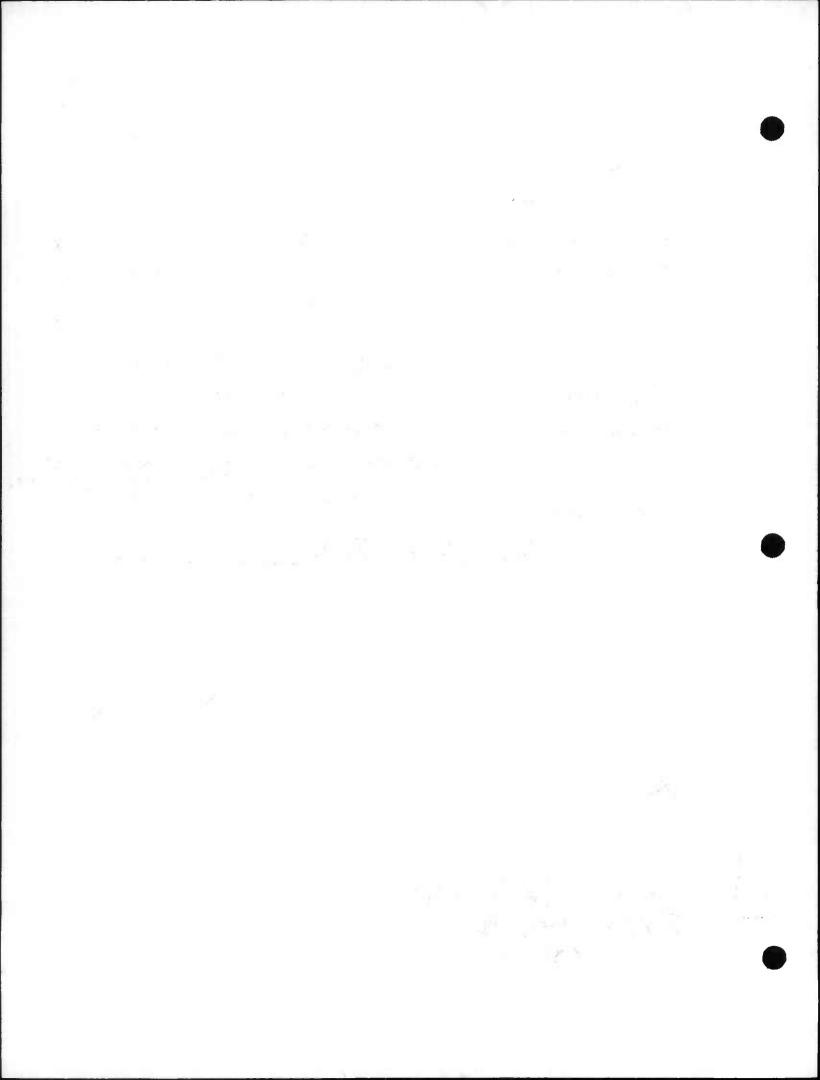
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	_					DEATH		HEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	Howar	rel				2. DATE OF MONTH	DEATH	- 9	YEAR	3. TIME OF DEATH
		SEX M 2 D F	8. AGE (In yrs. last I		F UNDER 1 YEAR HONTHS DAYS		7. DATE OF (Morith, D	lay, Year)	,	6. BIRTHI Country	PLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give street	and number)	271		9b. CITY, TOWN	OR LOCATION OF D			9c. COUN	ITY OF DE	EATH
DIRECTOR	RESIDENCE OF DECEDENT	MED	CIR		ANA	APOLIS			AN	VE F	PRUNDEL
H	10a. STATE 10b. COUNTY	1		0	TOWN OR LOC	ATION					10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER	F HRUX	VAEL	26	Vern	A PARK					1 YES 2 NO
FUNERAL	100. STREET AND NUMBER	Noive				2 1 14	4		10g. CITIZ	ZEN OF W	HAT COUNTRY?
S	11. MARITAL STATUS 12	. WAS DECEDENT	T EVER IN U.S. ARM	ED	13. WAS D	ECENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No —	14. RACE	— American Indian,
ВУ Е	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1	YES 2 NO		It yes,	specify Cuban, Mexico ES 2 D NO Specif	in, Puerto Rica	en, etc.)		Black Specif	, White, atc.
											WITITE
	15. DECEDENT'S EDUCATE (Specify only highest grade con		(Give	kind of wo	SUAL OCCUPA vk done during i	TION nost of working	16b. KI	ND OF BUS	INESS/INDI	USTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	,	NOT use	. (1	1		
MO	17. FATHER'S NAME (First, Middle, Last)		17	SEK	172 (16. MOTHER'S NA	ME /Eleat Mirk	dle Meiden	Sumama)		
	1	towar	. \			Fore	1 100, 11100	Sid, Maldell C	Janaine)	241	20
BE	19a. INFORMANT'S NAME (Type/Print)	IUICHN		MAILING A	DDRESS (Stree	and Number or Rural	Route Number,	City or Town	, State, Zip	Code)	RD
유	JEAN S HOW.	ARI	10	0 /	ATTON	Daile	Seller	I PA	et	mi)-	21146
	20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal		20b. PLACEAN			Neme of	DATE	20c. LOC	CATION - C	City or Ton	wn, State
- 1	4 Donation 5 Other (Specify)	Trom State	cemetery, crem	atory or other	er plece)	2/h	3-15	Gui	EN B	URN	ir MD
	21. SIGNATURE OF TUNERAL SERVICE LICENS	SEE		/ /	22. NAME	AND ADDRESS OF FA	CILITY 4/9	K RI	77 44 4	e Hu	14
	· Well. B	ma-			BARG	mark Fl	Se	100	1011.6	Bob	mi 21146
	23. PART 1/Enter the diseases, or com	plications that	caused the deal	h. Do no	t enter the n	node of dying, suc	h aa cerdiad	c or reapir	ratory arre	eat,	Approximate
- 4	ahock, or heart feilure. Liet	Only one ceut									Territorial Charles and
- 1	IMMEDIATE CAUSE (Finel	,,	oe on eech mie.								intarval Between Onset and Death
- 1	disease or condition		PD								
		Co		ENCE OF)	:						
NO	disease or condition	OUE TO	OR AS A CONSEQU								
ATION	disease or condition resulting in death) e Sequentially list conditions, if any, leading to immediate	OUE TO	DPD								
FICATION	Sequentially list conditions, if amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	OUE TO (OR AS A CONSEQU	ENCE OF):							
RTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS A CONSEQU	ENCE OF):							
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	OUE TO (OR AS A CONSEQU	ENCE OF):							Onset and Death
. 1	Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A CONSEQU	ENCE OF):		ng cause given in	Part I. 24	ia. WAS AN / PERFORI		24b.	Onset and Death WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
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EDICAL.	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions or	OUE TO (OR AS A CONSEQU	ENCE OF):	the underlyi		1	PERFORI	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
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EDICAL.	Sequentially list conditions, if amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions of the cause. Enter UNDERLYING conditions of the cause of	OSPITAL: Vinpetient 2 OSPITAL: Vinpetient 2 T 28e. OATE OF	OR AS A CONSEQUENCE OR AS	ENCE OF): Builting in	26. DTHER: Nursing Hc	PLACE OF DEATH (Ch	eck only one) 6 Other (S	PERFORI	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant conditions of EXAMINER? 1 YES 2 NO NEDICAL EXAMINER? 1 YES 2 NO Pending	OUE TO (OR AS A CONSEQUENCE OR AS	ENCE OF):	26. DTHER: Nursing Ho	PLACE OF DEATH (Ch	eck only one)	PERFORI	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
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BY PHYSICIAN: MEDICAL	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions or EXAMINER? 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Yes 2 NO	OSPITAL: Inpetient 2 28e. PLACE OF	OR AS A CONSEQUENCE OF AS	Builting in	26. II OF 28c. II W 1 L	PLACE OF DEATH (Ch	eck only one) 8 Other (S) 28d. OESCR	PERFORI	MED? NO	UREO	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
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BALTIMORE, MARYLAND 21215-0020

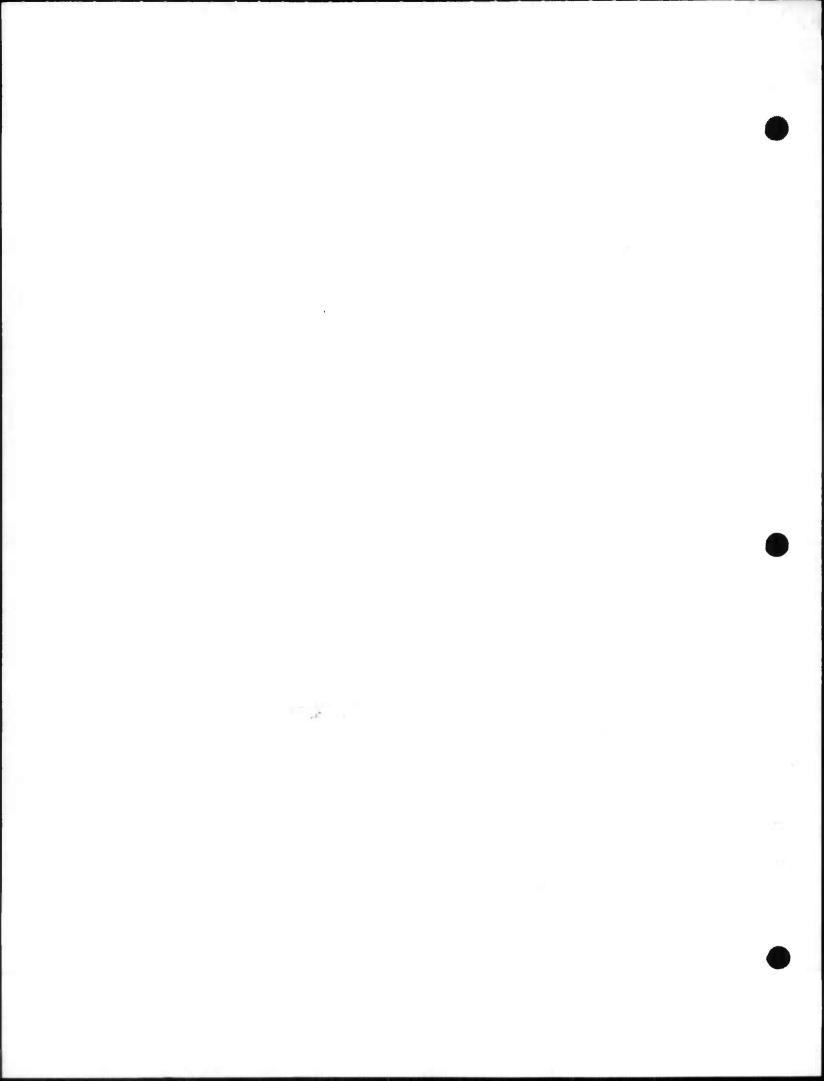
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

		REGISTRAR		CERTIF	ICATE OF	F DEATH		REG. NO.				
	15	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH		3.	TIME OF DEAT	тн
		HOLLIS	LEE	Н	OLTHAUS	S	0.3	1 4	199	YEAR	3:40	Рм
		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR		7. DATE C				CE (State or Fo	-
		505-38-6719	11/1/M 2 F E	56 YRS.	MONTHS DAYS	HOURS MIN.		9 193		Country)		
should	- 8	9s. FACILITY NAME (If not institution, give s		70	9b. CITY, TOWN	OR LOCATION OF D		7 193	9c. COUNTY	COLOT		
1, 2, 3 st	TOR	472 FAWNS WALK				POLIS			CANE SALES		UNDEL	
permit. Pages	DIRECTOR	MD Anne	. Arundel	10c. CIT	гу, тоши оп Loc						S. INSIDE CITY LIMITS? YES 2 X	
	FUNERAL	100. STREET AND NUMBER 472 Fawns Walk				101. ZIP CODE 2140	1				COUNTRY?	NO
ian. trans	쀨	11. MARITAL STATUS	12. WAS DECEDENT EVER II	N. 110 101150	40 100 00							
21215-0020 If or attending physician. For use as the burial-transit	BY	1 Never Married 2XX Merried 3 Widowed 4 Divorced	FORCES? 1 XXYES IF YES, GIVE WAR OR D 1958 - 197	2 NO	If yes, s	ECENDENT OF HISPA specify Cuban, Mexico Specific NO Specific	en, Puerto R	(Specify Yes o	or No- 14	Black, Wi Specify:		
1215 r attend use as	品	15. DECEDENT'S EOU	CATION	te. DECEDENT'S	USUAL OCCUPAT	TION	18b.	KIND OF BUSI	INESS/INDUS	TRY	Whi	TO
2 2 2	ш	(Specify only highest grade Elementary/Secondary (0-12)	College [1-4 or 5+)	(Give kind of life, Do NOT u	work done during n se retired.)	nost of working						
	립		5 plus	0	Officer		lun	ited S.	tates	Navi	1	
YLAND 2 by the hospital be detached to at once.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)			00	18. MOTHER'S NA						
A P		William Holthaus					lla L		,			
MARYLAND retained by the hospit should be detached notified at once.	BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	AOORESS (Street	end Number or Rural			, State, Zip Cc	ode)		
M. e rets	2	April A. Holthau	S			alk " "		apolis			!	
ALTIMORE, I seath. Page 6 may be funeral director, page xaminer must be n		20e. METHOD OF DISPOSITION 1 Burlet 2 A gremetion 3 Remo	200	D. PLACE AND DATE	OF DISPOSITION (Name of	OATE	20c LOC	ATION — CIN	v or Town	State	
O 4 5 E		1 Burlet 2 Fremetion 3 Remi	oval from State	T. LINCO	ther placet rom	atory 03.	-17-9	3 Bro	ntwoo	d Ma	urulan	d
ALTIM death. Page funeral dire examiner r		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	-	22. NAME	AND ADDRESS OF FA	ACILITY TO	Thu M.	Taul	on Fu	monal	Hom
ALT leath.		Vana			147 D	uke of G	louce	ston S	t An	nanol	is M	ก
B/ rs after d n by the removal.	-										, Ini	
in 24 hoursely filled Intration, of		PART I. Enter the diseases, or cahock, or heart fallure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one couse on a	erohiz	~	lode of dying, suc		^		ł	Approxima Interval B Onset sno	etween
P 2 0 2 0	7		DUE TO JOR AS	A CONSEQUENCE O	F):	v u sev	-12-1					
BOX 68 cate be execut hysiclan and c prior to buni r traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING										
E e g ca	윤	CAUSE (Disease or injury that initiated events	DUE TO (OR AS /	A CONSEQUENCE O	F):							
P.O. E ath certificat tending phy al Hygiene p or other	E	resulting in death) LAST			•					İ		
ta at le			1.									
ORDS, that the dea ned by the att ith and Menta any injury,	DICAL	PART II. Other significent condition	a contributing to death b	out not resulting	in the underlying	ng cause given in		24a. WAS AN A PERFORM YES 2	MED?	COR	RE AUTOPSY FI ILABLE PRIOR MPLETION OF C	TO
() 8 5 8 10	ME						_	Ries 21	_ NO		DEATH?	
REC v requires been sign t, of Heal shows										1	YES 2	NU
VITAL REC	SICIAN:	25. WAS CASE REFERRED TO MEDICAL			26. F	PLACE OF DEATH (Ch	neck only one)				
N: The N: The State State	잃	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outp	antions 3 [] DOS	OTHER:							
SICIA Certific	PHY	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIM		me 5/ Residence	T	(Specify)	HIRV OCCUR	DED.		
PHYSICI this cer with th		Netural 5 Pending	(Month, Day, Year)		JURY W	YES 2 NO	200. DESC	MIDE HOW IN	JOH! OCCOR	IEU		
ION OF VOING PHYSI The this cr r death with is marked,	BY	2 Accident Investigation 3 Suicide & Could set be	28e. PLACE OF INJURY	/ — At home, ferm			281 LOCA	TION (Street an	od Mumbas os	Quent Bouds	Alumbar	
S # S # S	COMPLETED	4 Homicide 8 Could not be determined	building, etc. (Spec	clfy)	, 1201019, 0111			Town, State)	a Number or	nure: Houle	Number,	
S S S S S S S S S S S S S S S S S S S	٦ ا	29e. CERTIFIER (Check only	CIAN: To the best of my know	riedge, death occurr	ed at the time, dat	e and place, and due	to the cour	e(e) and mann	or as stated			
SPITAL NERAL hin 72	Š		R: On the basis of examination							ause(e) enc	f manner se s	dated.
FUNERAL Within 72 I		296. SURNATURE AND TITLE OF CERTIFIES	7									
물을 없	8	// 11n /	ala d	$(\Lambda \lambda)$		29c. LICENSE NUI					nth, Day, Year)	
Pas	2	MAME AND ADDRESS OF PERSON WHO	COMPLETED CALIBE OF DE	ATH UTEM 27 (%-	Print)	0.C.N	4.E.		03	1/15/	/1993	
add)		JUARON LOU						_		-	010	0.1
		31. DATE FILED (Month, Day, Year)	12 DECISTRAD'S SIGN	ATURE		eet, Bal	Lt_1mc	re, N	naryl	and	212	UΙ
,		MAR 1 8 100		on Bindale	•							



BALTIMORE, MARYLAND 21215-0020	SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	he medical examiner must be notified at once.
PROSON OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPING ON ATTACONG PHYSICIAN: The law requires that the death certificate be executed within 2	TO THE FUNERAL MEMBERS. Mer this certificate has been signed by the attending physician and completely filled in by the filed within 72 hours after charth with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.	IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIF	TMENT OF I	EALTH AND DEATH	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last) WILLIAM M		HE	ENSON, S	R	2. DATE OF DEATH 1	w 93	EAR 1 28 PM			
	215-09-8937	M(X) M 2 □ F 8	yrs. lest birthdey) 5 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MARCH 19 1	.907	BIRTHPLACE (State or Foreign Country) MARYLAND			
TOR	99. FACILITY NAME (If not institution, give stree NORTH ARUNDEL HOSP RESIDENCE OF DECEDENT		ATION	9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE 9c. COUNTY OF DEATH A.A. COUNTY							
DIRECTOR	10e. STATE 10b. COUNTY	ARUNDEL	1	NSVILLE			10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	916 JOHNSON LANE			10	21032			OF WHAT COUNTRY?			
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 National American Divorced	2. WAS DECEDENT EVER IN 1 FORCES? 1 XYES IF YES, GIVE WAR OR DAT 1944 - 1945	2 NO	If yes, sp	ENDENT OF HISPAI ecity Cuben, Maxica 2 NO Specifi	NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)		RACE — American Indian, Black, White, etc. Specify: BLACK			
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	rion mpleted) College (1-4 or 5+)	(Give kind of w life. Do NOT us MAINTA	ork done during mo e retired.)	ON ast of working	16b. KIND OF BUS	SINESS/INDUS	TRY			
	17. FATHER'S NAME (First, Middle, Last) JAMES HENSON				16. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)				
TO BE	19a, INFORMANT'S NAME (Type/Print) PAULINE HENSON				nd Number or Rural	Route Number City or Town					
,	20a. METHOD OF DISPOSITION UNBurlel 2 □ Cremetion 3 □ Ramova 4 □ Donation 5 □ Other (Specify)		PLACE AND DATE O			3/17/93 C		OF TOWN, State			
	21. SIGNATURE OF FUNERAL SERVICE LICENS	7. Lees	٥	REESE		MORTUARY, F		401			
	23. PART I. Enter the diseases, Dr corr shock, Dr heart feilure. List IMMEDIATE CAUSE (Final	pilications that caused to boily one cause on esc	the death. Do n ch line.					Approximate Interval Batween			
	disease or condition resulting in death)	Me tels		ca	deno	Grei'	me	Onset and Death			
NOI	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C			nt y	A 008	mel	nan j			
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initisted events	DUE TO (OR AS A C	Deen CONSEQUENCE PE	los t	us o	nec	8 1				
	resulting in death) LAST	State	ns t	081-	Col	oston	7	•			
: MEDICAL	PART ii. Other significent conditions of the study of the significant conditions of the signific	Sur St	not resulting in	the underlying	cause given in	Part I. 24a. WAS AN PERFOR 1 YES 2	MED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IDSPITAL:		26. PL	ACE OF DEATH (Ch	eck anly one)					
нүѕ	1 YES 2 NO 1	28e. DATE OF INJURY	lent 3 DOA	4 Nursing Hom	URY AT	6 Other (Specify) 28d. DESCRIBE HOW II	JURY OCCUR	ED			
ВУ	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJE	M 1 🗆 1	RK? YES 2 NO						
ETED	3 Suicide 6 Could not be determined	26e. PLACE OF INJURY — building, etc. (Specify	- Al nome, term, st	reat, factory, office		28f. LOCATION (Street a City or Town, State)	nd Number or F	Bural Route Number,			
COMPLET		N: To the best of my knowled On the basis of examination of						ruse(a) end menner ae stated.			
BE	296. BIGNATURE AND TITLE OF CERTIFIER	0			29c. LICENSE NUI	ABER	29d. DATE SIG	GNED (Month, Day, Year)			
TO	DALJIT SAWHNEY, M	OMPLETED CAUSE OF DEAT 1.D./1600 CR	H (ITEM 27) (Type, AIN HIGH	WAY, SW	#201/GL	EN BURNIE,	MARYL	AND 21061			
	31. DATE FILED (Month, Day, Year) MAR 1 6 1993	32. REGISTRAR'S SIGNAT	Mindell								



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I'R ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may	CIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pai hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

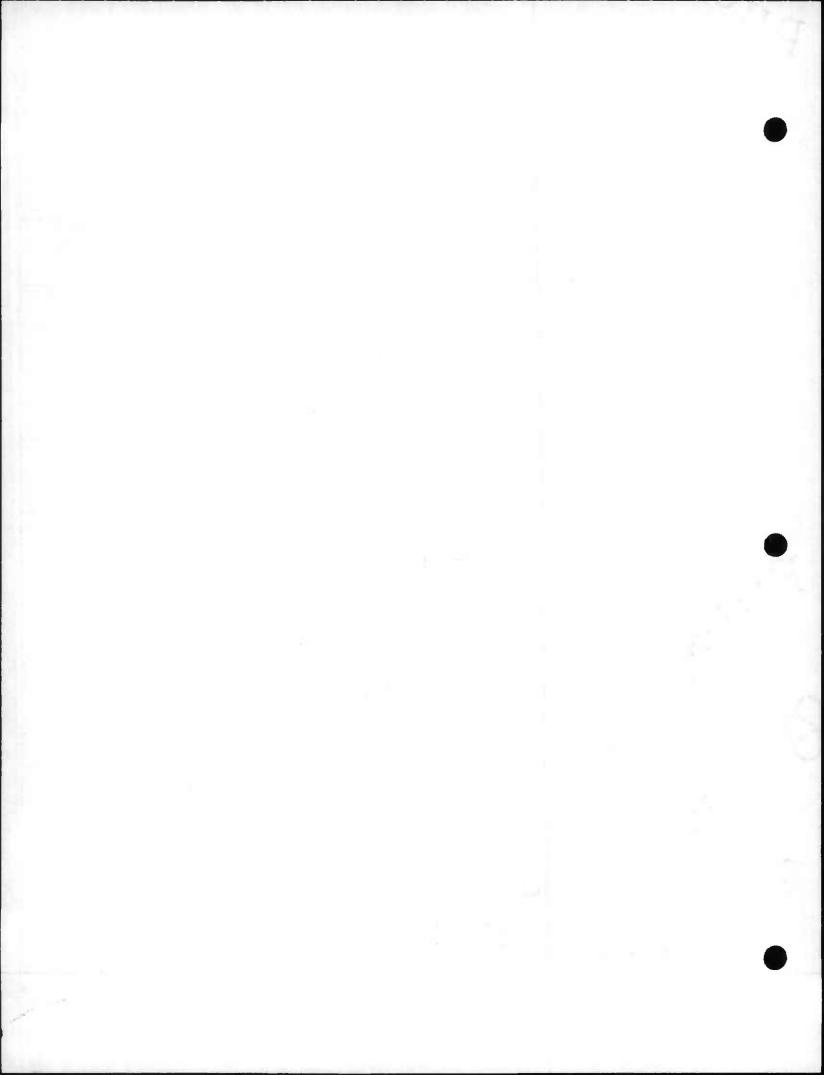
CERTIFICATE OF DEATH

REG. NO.

2. DATE OF DEATH

Trederick Mish Hill

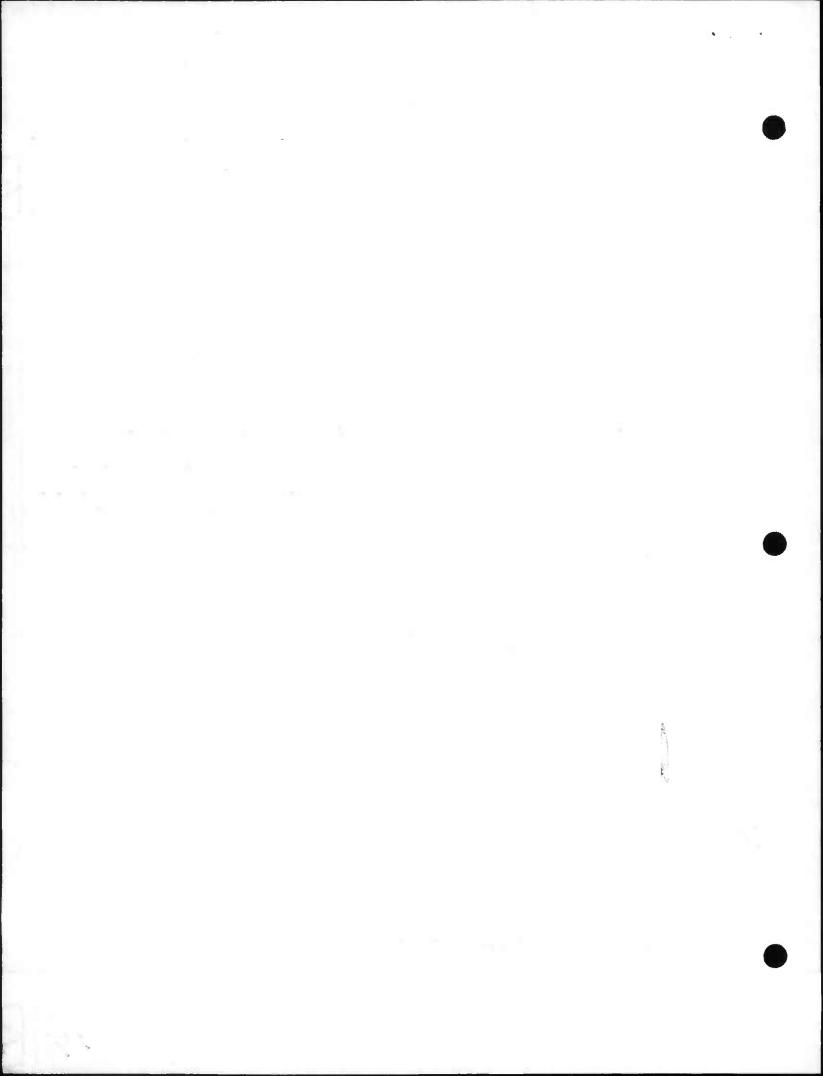
		1. DECEDENT'S NAME (First, Frederick		lull	-							2. DATE OF I	DEATH 13 ^D	w 199	3 YEAR	3. TIME OF DEATH 12:47 P. M		
		4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yrs. lest birthday)			IF UNDER 1 YEAR IF UNDER 24 HRS.			7. DATE OF E	MALH		a. BIRTI	IPLACE (State or Foreign			
		215-26-138		1X M 2 F	75		YRS.	MONTHS	DAYS	HOURS	MIN.	Jan. 2	7,1	918	Count	ryland		
1,		9a. FACILITY NAME (# not in			. 1			96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF I										
	DIRECTOR	Washington		Hospita	<u>ar</u>			Н	ager	stow	n			Was	shing	nington		
	E I	10e. STATE	10b, COUNTY			\neg			OR LOCAT	TION						10d. INSIDE CITY		
		Maryland		nington		Boonsboro									1 TES 2 NO			
	FUNERAL	17214 Baker		Road					101	ZIP COO	€ 1713					WHAT COUNTRY?		
	ON	11. MARITAL STATUS	IT EVER IN U.	S. ARM	ED	13	. WAS DEC			HC ORIGIN? (S	pecify Yes		JSA 14. BAC	E — American Indian,				
	BYF	1 Never Married 2 4 3 Widowed 4 Divo		FORCES?	X YES 2	S T.T.7	מי		It yes, sp	ecify Cub		n, Puerto Ricar			Spec	k, White, etc.		
			EDENT'S EDU			_	_	1101141	OCCUPATIO							white		
	COMPLEIED	(Specify only Elementary/Secondary (8	y highest grade	completed) College (1-4 or 5		(Give		work done	e during mo		ing	160. KJN	ID OF BUS	BINESS/IN	DUSTRY			
	4	9 years	,			ma	chir	nist				f	acto	ory				
oue 1	5	17. FATHER'S NAME (First, Mi										ME (First, Middl						
e pe	8	Frank Hull Virginia Hull																
notify C	2	Marguerite		1											and 21713			
st be		20a. METHOD OF DISPOSITI	ION	oval from State	20b. PL	ACEAN	DOATE	OF DISPO	SITION /Na	me of		DATE	20c. LO	CATION —	City or To	City or Town, State		
E		4 Donation 5 C Other	(Specify)		Res	t H	äver					3/17	Hag	gerst	own,	Maryland		
- Luc		22. NAME AND ADDRESS OF FACILITY Corald N. Minnigh 305 N. Dotomog Character Corald N. Minnigh 305 N. Dotomog Character Corald N. Minnigh														ac Street		
a ex		Funeral Home Hagerstown, Maryland																
ows any injury, or other traumatic event, the medical examinar must be notified at once.		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. IMMEDIATE CAUSE (Finel disease or condition.																
vent,		resulting in death)	7	DUE TO	(OR AS A CO	HSEOU	JENCE O	7 () F):	c_							8 monts		
atic e	ξ	Sequentially list conditi	lone T	b														
ry, or other traumatic	4	if any, leading to immed cause. Enter UNDERLYI	diate	DUE TO	(OR AS A CO	NSEQU	JENCE O	F):										
ther t	=	CAUSE (Disease or Inju that initiated events		DUE TO	(OR AS A CO	MSEOU	JENCE O	F):										
0 6	5	resulting in death) LAS	T L	d														
aluny.	- 11	PART II. Other significa	nt condition	s contributing to	death but i	not res	sulting	in the u	underlying	ceuse	given in	Part i. 24e	. WAS AN	AUTOPSY	24b	WERE AUTOPSY FINDINGS		
ws any Injury	3			Mrc			_						PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE		
2 NO	ME										_					OF DEATH?		
23 sh	2																	
ted, or item 23 s	3	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:				OTHE		ACE OF I	DEATH (Che	eck only one)						
9 7	2	1 YES 2 NO		1 Inpatient 2 28a. DATE OF	-	_	DOA 28b. TIM	4 🗆 Nu			esidence	6 Other (Sp 28d. DESCRI		N ICIDY OC	CUREO			
marked,	_		Pending Investigation	(Month, E				URY	wo	RK? (ES 2 [□ NO	200. DESCRIE	DE HOW I	NORT OC	CONED			
50 L	3	3 Suicide 6	Could not be determined	28e. PLACE C building,	F INJURY — i etc. (Specify)	At hom	e, farm, :	street, fa	ctory, office			261. LOCATIO City or To	N (Street a wn, State)	and Number	r or Rural I	Route Number,		
ELU		29a. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the best of	my knowledg	je, deat	h occum	ed at the	time, data	and place	, end due	to the cause(a) end man	ner as sta	ted.			
ANT: If ite	5															and manner so stated.		
ORTA DE C	u II	296. SIGNATURE AND TITLE	OF CERTIFIER							29c. LIC	ENSE NUN	ABER		29d. DAT	E SIGNED	(Month, Day, Year)		
IMPC TO DE	- 10	30. NAME AND ADDRESS OF	DEDECKI WITE	rehouse	6 1	n	0.	0.1		0	416	67		<u> </u>	3.1	3 93		
1		Michael	-	Corneck	DE OF DEATH	(ITEM	27) (Type,		//		, ,	j-L			00	2 2/2//2		
		31. DATE FILED (Month, Day, MAR 16 19		32. REGISTRA	R'S SIGNATU	RF. T	7	174	ue //	12	·cl·	1 1Zgr	-17	oun,	1916	2. 21740		
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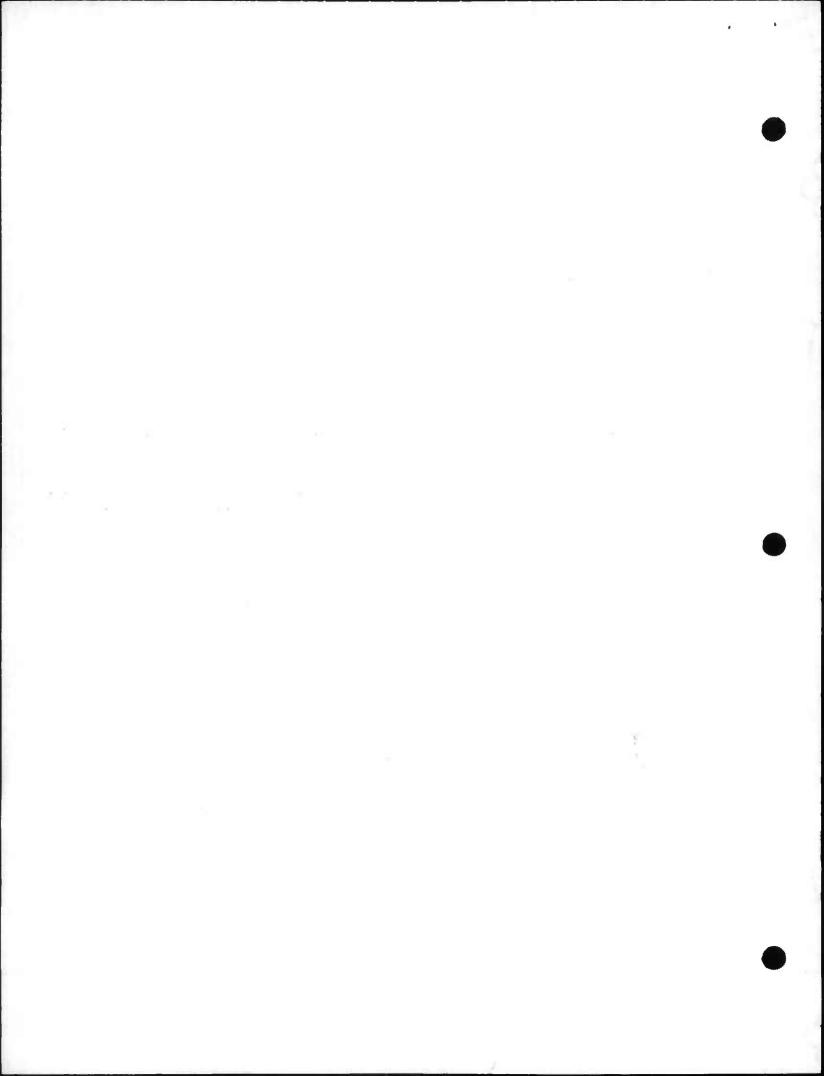
31. DATE FILED (Month, Day, Year)
MAR 17 93

		1 - FOR STATE REGISTRAR	STATE OF MARYL		ARTMENT OF			NTAL HYGIEN REG. NO.				
		1. DECEDENT'S NAME (First, Middle, Lest) MARGARET MAI	E HAGY				2. M	DATE OF DEATH MONTH 16,	** 1993 **	3. TIME OF DEATH 10:35 P.		
P		4. SOCIAL SECURITY NUMBER 215-68-0037	5. SEX 6. AGE ('In yrs, leat birthda YRS	ASDAFFUS DAY		es 7	DATE OF BIRTH (Month, Day, Year) 1		BIRTHPLACE (State or Foreign Country) Lrginia		
2, 3 should	CTOR	99. FACILITY NAME (If not institution, give st Fallston General				n on Location 1ston	OF DEATH		Harf			
it. Pages 1,	DIRE	10a. STATE 10b. COUNTY	ford	10c. (Edgew				10d. INSIDE CITY LIMITS? 1 YES 2 NO			
n. ansit permit.	VERAL	2002 Armstrong S	Street		2	104. ZIP CODE 1040			10g. CITIZEN USA	OF WHAT COUNTRY?		
215-0020 attending physician. se as the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 AM Midowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 1 YES IF YES, GIVE WAR OR DA	2 2 NO	If yes,	specify Cuban, I		ORIGIN? (Specify Yea uerto Rican, etc.)	s or No.— 14.	RACE — American Indian, Black, White, etc. Specify: White		
D 2121 opital or atte	APLETED	15. DECEDENT'S EDUK (Specify only highest grade Elementary/Secondary (0-12)		(Give kind life. Do NO	's usual occupy of work done during use retired.) SEWITE	NTION most of working		166. KIND OF BUS		RY		
2 8 8 E	BE COMPL	17. FATHER'S NAME (First, Middle, Lest) Posey — Cop	pybuarger			18. MOTHER Mary		First, Middle, Melden ane (1	Sumama) unknowi	n)		
ay be retained page 5 should be notified	2 1	orothy L. Ruttinge	, Perrym	Town, State, Zip Code) Tman, Md. 21130								
e 6 m		20s. METHOD OF DISPOSITION Surfel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of complete, cremation of c										
SAL r death ne fune al.	uL.	Howard K'	McCom	25111	How 1317	ard K. Cokesb	McCo ury	mas III 1 Road, Ab	ingdon	l Home, P.A. , Md. 21009		
within 24 hours npletely filled in termation, or re-		23. PART I. Enter the diseases, or o shock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	List only one ceuse on e	consequence	Fa	lure	ı			Approximate interval Between Onset and Deat Acry S		
the death certificate be executed the attending physician and con if Memtal Hygiene prior to buriat, injury, or other traumatic e	CERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST Becurrent Aspiration pneumonia, DUE TO (OR AS A CONSEQUENCE OF): Becurrent Aspiration pneumonia, Due To (OR AS A CONSEQUENCE OF): C. Pseudobulbac pals y DUE TO (OR AS A CONSEQUENCE OF): A. Multi mfarct dementa										
HECORD Hequires that the signed by the of Health and M	MEDICAL	PART II. Other significant condition Service Vr: nary Tro	s contributing to death b	20		AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS MANILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
VII AL. ZAN: The law rithcate has b he State Dept or Item 23	YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	atient 3 🗆 DO/	OTHER:	PLACE OF DEAT						
or this certification with the Si	ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)		M 1 [INJURY AT WORK?		d. DESCRIBE HOW II	NJURY OCCUR	ED		
	ED	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Spec	— At home, farr	n, street, factory, o	ffice	281	City or Town, State)		lural Poute Number,		
FUNERA Within 72 R	COMPLET		CIAN: To the best of my knowledge. R: On the bests of examination							ruse(s) and manner as stated.		
TO THE HOSP TO THE FUNE be filed within	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	Uld m	O		29c. LICENS	35	522	29d. DATE SIG	SNED (Month, Day, Year)		
	-	620 Boulton	YeeT	ATH (ITEM 27) (1)		m	1	210	14			



08812 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. FOR STATE REGISTRAR 1 -

		1. DECEDENT'S NAME (First,	, Middle, Last)										OF DEATH			3. TIME OF OEATH
•			SYDNEY	LEE H	LEE HART								ch 15		993	11:10 A M
		4. SOCIAL SECURITY NUME	BER	5. SEX	SEX 6. AGE (In yrs. lest birthday)						7. DATE	OF BIRTH		0. BIRTH	IPLACE (State or Foreign	
	1 3	216-18-602	2	1 🗌 M 2 💢 F	69	9	YRS.	PONTHS	DAYS	HOURS	MIN.	Mar	ch 3,1	924	Countr	yland
3 should		9a. FACILITY NAME (If not in				9b. CITY,	TOWN	OR LOCATI	ON OF DE		CII J,		NTY OF D			
	E C	Harford Mer	mrial	Hospita	1		Havre de Grac								Harf	ord
1, 2,	5	RESIDENCE OF DEC	CEDENT												i i dr. T	ora
Sade	DIRECTOR	10a. STATE	10b. COUNTY				10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY LIMITS?
Ę.		Maryland 100. STREET AND NUMBER		ford			Havre de Grace									1 TYES 2 NO
physician. burial-transit permit. Pages 1,	FUNERAL								10		_					VHAT COUNTRY?
trans	빌	4105 Chapel	Ra.	12. WAS DECEDEN	AT EVEN IN	1110 400	150	40.			078				USA	
physic		1 Never Married 2 🖔	Married	FORCES?	YES	2 X N		- 1	f yes, sp	pecify Cubs	n, Mexica	n, Puerto Rican, etc.) Blac				— American Indian, c, White, etc.
or attending physician r use as the burial-trar	B	3 Widowed 4 Divo	erced	IF YES, GIVE Y	HAR OR DA	NIES		'	☐ YES	2 X NO	Specify	r:			Speci	white
by the hospital or attending be detached for use as the at once.		15. OEC (Specify only	EDENT'S EOU	CATION completed		16a. DEC	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working					168	. KINO OF BUS	SINESS/INC	DUSTRY	
for u		Elementary/Secondary (0		College (1-4 or 5	+)	Me.	Do NOT use	retired.)		Dat Or WORM	'V					
the hospital detached for once.	COMPL			1		_	Home	make	er							
the hose detach	임	17. FATHER'S NAME (First, M										,	Middle, Maiden	Sumame)		
	H	William Fi		n Dunn							lvia			Lowm		
retained by 5 should be notified at	2	Robert C. H									ober, City or Town			70		
2 8 0		20a. METHOD OF DISPOSIT			000				_		Havr	7	Grace	CATION -		
24 nours after death. Page 6 may be filled in by the funeral director, page ion, or removal.		1 X Burial 2 Crematio	n 3 🗆 Rem	oval from State	cem	etery cres	natory or oth	er nlecel				DAT	7.7.			
Page dire		21. SIGNATURE OF FUNERA		CENSEE	Пс	TLIOI	u Me	22.	NAME A	NO ADDRE	SS OF FA	OLTA	<u>-9b A</u>	Tain), M	aryland
death. Pag s funeral dir l. examiner	1	Howard K. McComas III Funeral Home 1317 Cokesbury Rd., Abingdon, Md.														
the the towal.	\vdash	No 190 Va		MG B	Ma	AI	1/	113	317	Coke	sbur	y Rd	., Abi	ngdo	a, Ma	1. 21009
d in by the or removal		23. PART I. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate														Approximata Interval Between
24 not filled ion, of		IMMEDIATE CALIFE (Float														Onset and Desth
executed within 24 and completely fills o burial, cremation, matic event, the		disease or condition resulting in desth) a. Out of the consequence on:														
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e be execut sician and c rior to buris traumatic	CERTIFICATION	Sequentially list condition if any, leading to immediate		DUE TO	DUE TO (OR AS A CONSEQUENCE OF):											
ficate be physician ne prior t	3	cause. Enter UNDERLYI CAUSE (Disease or Inju	ING	C												
nding phy Hygiene p	틸	that initiated events		OUE TO	(OR AS A	CONSEO	UENCE OF)									
ath ca trendi	ER	resulting in death) LAS		d												
the deal y the att d Menta injury.		PART II. Other significa	nt condition	s contributing to	death be	ut not re	suiting in	tha un	dariyin	g cause g	given in	Part I. 24a, WAS AN AUTOPSY			24b	WERE AUTOPSY FINDINGS
that the hed by the and any is	MEDICAL												PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
quires n signe f Health	9											_	1 YES 2	□ NO		OF CEATH?
5 5 0 E												-			1	I IES 20 NO
he law b has t e Dept m 23	HAN:	25. WAS CASE REFERRED TO	O MEDICAL						28. P	LACE OF D	EATH (Che	ock only o	ne)			
SiCIAN: The certificate h the State I	Sic	EXAMINER?		HOSPITAL:	☐ ER/Outp	atient 3		OTHER Wun		ne 5 🗆 Re	sidence	8 🗆 Othe	er (Specify)			
this cer with th	PHYSICI	27. MANNER OF OEATH		28s. GATE Of (Month, E	F INJURY		28b. TIME INJU			JURY AT		28d. DE	SCRIBE HOW II	NJURY OC	CURED	
NG PHYS fter this eath with	ВУ		Pending Investigation					М		YES 2	NO					
R: Aff			Could not be	28s. PLACE (building,	of INJURY	— At hor	ne, farm, st	eet, fact	ory, offic	CB		28f. LOC	CATION (Street a	and Number	or Rural F	loute Number,
IPITAL OR ATTENDING PHYSICIAN: The law IERAL DIRECTOR: After this certificate has bi in 72 hours after death with the State Dept. IT: If Item 28 is marked, or Item 23:	ETE		detsrmined										10. 1991			
TAL OR A AL DIRE 72 hours If Item	됩										use(s) and man					
29s. CERTIFIER (Check only one) 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.											ne cause(s) and manner as stated.				
A FIGURE	ш	29b. SIGNATURE AND TITLE	OF CERTIFIE	R					_	290 LICI	ENSE NUN	IBER		29d. DAT	E SIGNEO	(Mg/tth, Day, Year)
222	0 B	Cleuc	W				131712 1 3/17/93						193			
	F	30. NAME AND ADDRESS OF	F PERSON WH	O COMPLETEO CAU	SE OF DE	ATH (ITEM	27) (Type, I	Print)	1	1 .01		110	000-	-, ,	11.5	
100		CHIRLES !	ECK	VUL L	19	W	BUL	All	2.	1 Cla	-1	WE	2000	V, I	M	2/001
31. DATE FILED (Morith, Day, Year) 92. SEGISTRAN'S SIGNATURE STATE AND AND AND AND AND AND AND AND AND AND																



BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should a lithin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

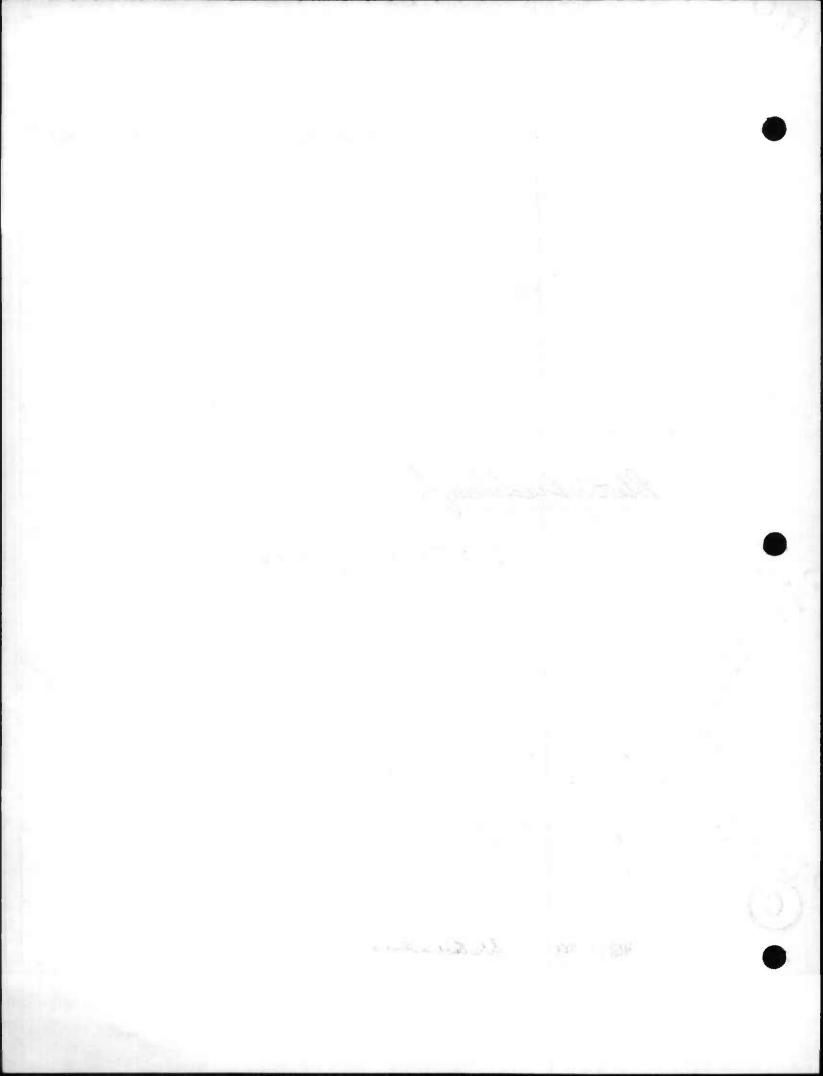
PORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last FRANCES CATH) ERINE HOUSE	ER .			2. DATE OF DEATH MONTH 12,	**1993	3. TIME OF DEATH 1:35 P. M	
	4. SOCIAL SECURITY NUMBER 053-09-7648-A	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan. 9,1910 8. BIRTHPLACE (State or Re Country) New York			
TOR	9a. FACILITY NAME (# not institution, give Harford Memorial			de Grace	HTA	9c. COUNTY	r of DEATH rford		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	TY	10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY	
	Maryland	Harford		Joppa				LIMITS? 1 ☐ YES 3√☐ NO	
FUNERAL	100. STREET AND NUMBER 115 Orsburn Dr	ive		10f	21085	5	10g. CITIZEN OF WHAT COUNTRY? USA		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	13. WAS DEC	s or No 14	Black, White, etc. Specify:			
	15. DECEDENT'S ED	UCATION	16a. DECEDENT'S U			16b. KIND OF BU	ISINESS/INDUS	White	
COMPLETED	(Specify only highest grad Elementary/Secondary (0-12)	Coffege (1-4 or 5+)	Housewij		st of working	Hom	е		
SO	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)		
BE	Harrison Moses	Fleury		-	Anna		stein		
2	194. INFORMANT'S NAME (Type/Print) James Paul Hous	er				Poute Number, City or Tov		ode)	
	20a. METHOD OF DISPOSITION	200	. PLACE AND DATE OF	-				y or Town, State	
	1 Burlal 2 Tremation 3 Re 4 Donation 5 Other (Specify)	moval from State Cen	netery, cremetory or other	er plece)		5-93 W.			
	21. SIGNATURE OF FUNERAL SERVICE I	JCENSEE	_	22. NAME AN	ID ADDRESS OF FA	CILITY			
	LEWARE K. W	la Comes	211	1317	.a.k. McC Cokesbur	onias III.	runera bingdo	1 Home, P.A. n, Md. 21009	
	23. PART I. Enter the diseases, or shock, or heart fellure	Liet only one cause on a	ach line	t enter the mo	de of dyling, suci	h aa cardlac or resp	iratory arrest	t, Approximate	
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Pul	mona	y Emi	John	_		Onset and Death	
Z	IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (DR AS A CONSEQUENCE OF) Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	0	F)	1,			
FIC	CAUSE (Disease or injury that initiated events	c. DUE TO (DR AS /	CONSEDUENCE OF	ret	1 all	Cue			
ERT	resulting in death) LAST	d							
AL CI	PART II. Other significant condition	one contributing to deeth t	ut not resulting in	the underlying	cause given in	Part I. 24a, WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS	
SICA						1 YES :	1 1	MAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIC								OF DEATH?	
ž									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	ACE OF DEATH (Ch				
ΗXS	1 YES 2 NO	1 Propetient 2 ER/Outs 28s. DATE OF INJURY	patient 3 DOA 28b. TIME			8 Other (Specify) 28d. DESCRIBE HOW	IN HIRD OCCUR	250	
	1 Natural 5 Pending	(Month, Day, Year)	INJU	RY WO	RK?	200. DESCRIBE NOW	INJUNT OCCUP	ico	
D BY	3 Suicide 6 Could not be	28e. PLACE OF INJURY	— At home, ferm, str	reet, factory, office	,	281. LOCATION (Street City or Town, State	and Number or	Rural Route Number,	
ETE	4 Homicide determined					City or rown, State	,		
COMPLETED		SICIAN: To the best of my know VER: On the bests of sxamination						ause(s) and manner as stated,	
BE C	296, SIGNATURE AND TITLE OF CERTIFI	ER / / /			29c. LICENSE NUN	1BER	29d. DATE S	IGNED (Month, Day, Year)	
TO B	How Now	chowel 1	no		D08096		1/2/	493	
۴	30. NAME AND ADDRESS OF PERSON W	HD COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, F		5- N.M.	AIN ST	BOZI	AIR, MD21014	
	31. DATE FILEMAR", 205493	32. RESISTRAR'S SIGN	ATURE TO						

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ENDI	R: A	er de	I In
ATT	IERAL DIRECTOR:	rs aft	200
L OF	L DIF	2 hou	I lane
SPITAL OR ATTENDING PHYSICIAN: I	NERA	hin 72 hours after death with 1	Mr. 16 liam 20 la marked

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF		MENTAL HYGIEN	-	
	1. DECEDENT'S NAME (First, Middle, Last) CAROLYN	E. HEN	ISHAW- <	(STER	LING)	2. DATE OF DEATH	WY YE	3. TIME OF DEATH A
	4. SOCIAL SECURITY NUMBER 214–42–9529	5. SEX 6. AGE ((In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. B	HRTHPLACE (State or Foreign ountry) nnsylvania
TOR	9a. FACILITY NAME (If not institution, give at PENINSULA REGION RESIDENCE OF DECEDENT		OR LOCATION OF D	9c. COUNTY	TY OF DEATH			
DIRECTOR	10a. STATE 10b. COUNTY	erset	10c. CITY	Y, TOWN OR LOCA				10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER 26420 E. Main St.	, Ext.		.10	ον. ZIP CODE 21817			OF WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DO	2 NO	If yes, s		NIC ORIGIN? (Specify Yean, Puerto Rican, etc.) //y:	- 3	RACE — American Indian, Black, White, etc. Specify: White
COMPLETED	15. DECEOENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) H.S. Graduate	CATION completed) College (1-4 or 5+) 4 Years	Me. Do NOT us	work done during m	ost of working	166. KIND OF BU	siness/industri	
	17. FATHER'S NAME (First, Middle, Last) J. Harry Henshaw	4 years	Interio	or becor	18. MOTHER'S NA	AME (First, Middle, Maiden n (Carrie)	Sumame)	ngs
TO BE	19a. INFORMANT'S NAME (Type/Print) Stanley C. Sterlin	ng (Husband)				Route Number, City or Tox		0)
	20a. METHOD OF DISPOSITION 1	oval from State 20b	PLACE AND DATE OF THE PLACE AND DATE OF THE	OF DISPOSITION (A	lame of	OATE 20c. LC	alisbur	
	21. SIGNATURE OF SUMERAL SERVICE LICE Robert H. Brace	dshaw, Jr.	1	Brads 306 W	haw & Son Main S	ns Funeral t Crisf	Home	
	23. PART I. Enter the diseases, or canock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. Matast	ach line.	mot enter the m	Come	ch aa cardiec or resp	Iratory arrest,	Approximate interval Between Onset and Death
NO	Sequentially list conditions,	b	CONSEQUENCE OF	n: J				
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c	CONSEQUENCE OF					
AL CEF	PART II. Other significant condition	d	ut not resulting i	in the underlyli	ng cause given in	Part I. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
MEDIC						1 YES	RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				LACE OF DEATH (C)	heck only one)		
YSIG	1 TES 2 NO	HOSPITAL:	etlent 3 🗆 DOA	OTHER: 4 Nursing Ho	ne 5 🗆 Residence	8 Other (Specify)		
ву Рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI INJ	URY W	JURY AT ORK? YES 2 NO	28d, DESCRIBE HOW	INJURY OCCURE	D
	3 Suicide 8 Could not be 4 Homicide determined	26a. PLACE OF INJURY building, etc. (Spec	— At home, farm, a	street, factory, offi	ca .	281. LOCATION (Street City or Town, State		ural Route Number,
COMPLET		CIAN: To the best of my know						use(a) and manner as stated.
TO BE	296. SIGNATURE NO TITLE OF CERTIFIER	o MAD			29c. LICENSE NU	MBER 0507	29d. DATE SIG	INED (Month, Day, Year)
	Joseph N. (COMPLETED CAUSE OF DE	145 E	3, CAR	ROY S	+ Spris	LUKI	nano
	31. DATE FILEO (Month, Day, Year) WAR 1 5 '93	32. REGISTRAR'S SIGN	ridson-Rand	1000			,	



. BOX 68760, BALTIMORE, MARYLAND 21215-0020	INSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	d, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be ex	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the it be filled within 72 hours after death with the State Dept, of Heath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traum:

	FOR 1 - STATE REGISTRAR	STATE OF I						MENTAL HYGI		93	08815
	1. DECEDENT'S NAME (First, Middle, Last)		C	CRITICIN	CATI	E OF	DEATH	REG.			
		USER						2. DATE OF DEATH MONTH	DAY	YEAR	3. TIME OF DEATH
			Comment of the Commen					March 7	, 19	_	0,102 BM
	4. SOCIAL SECURITY NUMBER 223-48-5172	6. SEX	6. AGE (In yrs. let	yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		(Month, Day, Year	(Month, Day, Year) Cou		PLACE (State or Foreign ny) Syland		
	9a. FACILITY NAME (If not institution, give	atreet and number)			9b. CITY	Y, TOWN O	R LOCATION OF D	EATH	9c. CO	UNTY OF D	PEATH
TOR	Garrett Co. Memo	orial Hos	pital		C	ak1a	ınd		Gar	rett	
DIRECTOR	10a. STATE 10b. COUNT	rrett		10c, CITY,	town o		ION				10d. INSIDE CITY LIMITS? 1 YES 2 NO
	10e. STREET AND NUMBER					101	ZIP CODE		10a Cr	TIZEN OF V	WHAT COUNTRY?
FUNERAL	Rt. 1 Box 5540						21550			SA	WHAT COOKINY?
BY FUR	11. MARITAL STATUS 1 Never Married 2 Married		T EVER IN U.S. AF			If yes, spe		NIC ORIGIN? (Specify an, Puerto Rican, etc.) fy:		14. RACI Blac Spec	E — American Indian, k, White, etc.
	3 Widowed 4 Divorced	Korea	an War								White
E	15. DECEDENT'S EDU (Specify only highest grad	JCATION completed)	16a. DE	CEDENT'S U	SUAL O	CCUPATIO	N st of working	166, KIND OF	BUSINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	+)	ive kind of wo Do NOT use arpent			or or morning	Gener	al Car	rpent	rv
8	17. FATHER'S NAME (First, Middle, Last)			-			40 MOTHER'S N	AME (First, Middle, Mair		Police	/
BE C		auser					Haze1	Pearle	Roth		
TO E	19a. INFORMANT'S NAME (TyperPrint) 19b. Mail.ing Address (Street and Number or Rural Acute Number, City or Town, State, Zip Code) Luke W. Hauser, Jr. 513 Skyline Lakes Dr. Ringwood, N.J. 07456									07456	
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) DATE 20b. PLACE AND DATE Of DISPOSITION (Name of Specify) Crematory of other page) St. John S Cemetery 3/10 Red House, Maryland										
	21. SIGNATURE OF THERAL SERVICE AS	Dust	M0016		22.	NAME AN	D ADDRESS OF FA	AH 1771	P.O. 1	Box 2	43
NC	23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions.	a. Due to	te Gre (OR AS A CONSEI LOS JUNE	DIK OUENCE OF):	5			ch as cardiac or re	spiretory a	rrest,	Approximata interval Between Onset and Death 4 decy
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c	(OR AS A CONSEC								
PHYSICIAN: MEDICAL	PART II. Other algorificant condition Hyperblus Ver Algorithm	PERFORMED? 1 YES 25 NO OF DEA							WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
A	25. WAS CASE REFERRED TO MEDICAL					26. PI	ACE OF DEATH (Ch	sectroniv one)			
VSIC	EXAMINER?	HOSPITAL:	ER/Outpatient 3		OTHEI	Rt:		6 Other (Specify)			
ВУ РН	27. MANNER OF CEATH 1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF (Month, D	25a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? M 1 YES 2 NO					28d. DESCRIBE HO	W INJURY O	CCURED	
8	3 Suicide 6 Could not be 4 Hornicide determined	28e. PLACE O building,	F INJURY — At ho	oma, farm, atr	eet, fact	tory, office		261. LOCATION (Stree City or Town, Str	et and Numbe ate)	or or Rural F	Route Number,
COMPLET	29a. CERTIFIER (Check only one) 2							to the cause(s) and i			and manner as stated.
O BE C	296. SIGNATURE AND TITLE OF CERTIFIE	R					29c. LICENSE NUI		29d, DA	TE SIGNED	(Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Robert Coughlin, M.D. Eglon Clinic Eglon, W. Va. 26716

31. DATE FILED (Month, Day, Year)
MAR - 9 1993 relia Davidson

1 - STATE REGISTRAR

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	The state of the s
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	1. DECEDENT'S NAME (First, Middle, Last	0)	CERTIFIC		REG. N	0.	3. TIME OF DEATH		
	LeR	English Control of the Control of th				, 1993 YE			
	4. SOCIAL SECURITY NUMBER 579-05-4702	5. SEX 6. AGE	7. DATE OF BIRTH (Month, Day, Year) Peb a 17, 1911 Maryland						
OR	9a. FACILITY NAME (If not institution, give Calvert Memoria			96. CITY, TOWN OR LOCATION OF Prince Freder		9c. COUNTY C	of DEATH Lvert		
RECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN			TOWN OR LOCATION	10d. INSIDE CITY				
L DIR	Maryland Ca	alvert	St	Leonard 101, ZIP CODE		100 CITIZEN	1 ☐ YES 2 🗵 N		
FUNERAL	4430 Williams	s Wharf Roa	ad	20685			ted State		
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Diverced	The second secon				3	RACE — American Indian Black, White, etc. Specify: " Jaucasian		
ETED	15, DECEDENT'S ED (Specify only highest gra-	de completed)	16a, DECEDENT'S US (Give kind of wo	vrk done during most of working	16b, KIND OF B	USINESS/INDUST			
COMPLE	Elementary/Secondary (0-12) College (1-4 or 5 +) Farmer				Agri	cultur	re		
BE CO	Charles Emory Hall Estelle Minerva Bowen								
5	19a. INFORMANT'S NAME (Type/Print) Thelm E. Phibl	bons Hall	196. MAILING A 4430 V	NOORESS (Street and Number or Aun Villiams Wha	of Rd., S	own, State, Zip Code	nard, Md		
	20s, METHOD OF DISPOSITION 1 (2) Burlet 2 Cremetton 3 Removel from State 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, cremetory or other place)								
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE I	LICENSEE	Asbury M	lethodist		arstow,	Marylan		
	Clark, L. Bell, Prince Frederick, Md. 20678								
ATION	disease or condition resulting in death) a. **Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Lesperatory faulture Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
RTIFIC									
L CERTIFICATION		d.	but not resulting in		in Part I. 24e. WAS A	N AUTOPSY	24b. WERE AUTOPSY FIN		
AL	PART II. Other algorificant conditions and the supplemental supplement	,	but not resulting in	the underlying cause given i	PERF	ORMED?	AMAILABLE PRIOR TO COMPLETION OF CA OF DEATH?		
MEDICAL	PART II. Other algorificant conditions and the supplemental supplement	ons contributing to death	Pulmer deova	the underlying cause given i	PERF	ORMED?	AMAILABLE PRIOR TO COMPLETION OF CAL OF DEATH?		
MEDICAL	PART II. Other algorificant condition Lymphoma Clinonic Oli Atheres Cle 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	structue	Pulme	the underlying cause given in the underlying cause given in the cause given given in the cause given in the cause given in the cause given give	PERFO	ORMED?	AMAILABLE PRIOR TO COMPLETION OF CA OF DEATH?		
AL	PART II. Other algorificant conditions and the second conditions are selected as the second conditions are s	structure notic Ca	Pulmer deova	28. PLACE OF DEATH (I	PERFO	PRMED?	1 YES 2 NO		
ED BY PHYSICIAN: MEDICAL	PART II. Other aignificant condition Lymphom of Clinonic Old Sthere S Cle 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1) Inpetient 2 ER/Ou 28e. DATE OF INJURY (Month, Day, Year)	Pulova ripetiont 3 DDA 4 28b. TIME: INJUE RY — At home, farm, str	28. PLACE OF DEATH (I WORK? 1 YES 2 NO	PERFO	PAMED? 2 NO INJURY OCCURE t and Number or Ru	AMAILABLE PRIOR TO COMPLETION OF CA OF DEATH? 1 YES 2 NC		
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AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	 U. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the 	11	filten 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
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	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)		C	ERTIF	ICAT	E OF	UEA	AI FI	REG. N 2. DATE OF DEATH MONTH		YEAR 3	TIME OF DEATN	
	Grant Sims							March 14		3	7:45 A		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)				-	7. DATE OF BIRTN (Month, Day, Year)		8. BIRTHPL Country)	ACE (State or Foreign	
	236-03-6380 1½ M 2 🗆 F 78 YRS. MONTHS DAYS HOURS MIN.								June 18,	1914	Mary	land	
	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN								EATN	9c. COUN	TY OF DEA	тн	
Ö	Garrett County Memorial Hospital Oakland Garre										arret	t	
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Ž	11. MARITAL STATUS		IT EVER IN U.S. AF	MED	13.	WAS DEC	ENDENT		IIC ORIGIN? (Specify)			American Indian	
	1 Never Married 2 Married		YES 2 XI	NO		If yes, sp	ecify Cub	oan, Mexicas O Specify	n, Puerto Rican, etc.)			American Indian, filta, atc.	
1	3 Widowed 4 Divorced						LA	э эрвску	,.		Specify:	White	
E	15. DECEDENT'S EDU (Specify only highest grade		(G	CEDENT'S	work done	during ma	ON set of word	kina	16b. KIND OF B	USINESS/IND	USTRY		
T I	Elementary/Secondary (0-12)	College (1-4 or 5	+) //0	. Do NOT u	se retired.)								
E	8		Farr	ner/E	leavy	Equ			. Farmer		vy Eq	uip. Oper	
COMP	17. FATHER'S NAME (First, Middle, Last)						16. MO	THER'S NAI	ME (First, Middle, Maide	on Surname)			
	Scott		Harvey					Lucin				mill	
2	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	\$ (Street a	t and Number or Rural Route Number, City or Town, State, Zip Code)						
	Lottie I. Harvey		I	Rt. 3	, Bo	x 7	75,	0ak1	and, MD	21550			
	20s. METNOD OF DISPOSITION 1 20b. PLACE AND DATE Of DISPOSITION (Name of camp(gry, crematory of other place) 20c. LOCATION — City or Town, State												
	4 □ Donation 5 □ Other (Specify) White Church Cemetery 3/17 Oakland, Maryland												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SET OF JOINT FOR THE PROPERTY OF												
33	Stewart Funeral Home 32 S. Second St., Oakland, MD 21550									21550			
	22 DART I Enter the dispessor or complications that several the death to the several the death to the several the death to the several than the several the several than the sev										Approximate		
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	disease or condition resulting in death)	Condi	an1man.		****	. da							
	resulting in death)	DUE TO	OP AS A CONSE	OUENCE O	F):) L							
FULL	Sequentially list conditions, if any, leading to immediate b. Atherosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF):												
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2 Accident Investigation " 1 YES 2 NO								- 1	261. LOCATION (Street	t and Mumber	or Primit Board	a Mumbas	
	3 Suicide 6 Could not be 4 Homicide determined	building,	etc. (Specify)	,		,			City or Town, Stat		or Horar House	a Number,	
1	On Continue												
100	298. CENTIFIER 1 TO CEPTIFYING PHYSICIAN: To the head of my boundades death account at the first								anner as stated.				
	(Check only 1 X CERTIFTING PRTS		(Check only one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.										
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	(Check only 1 X CERTIFTING PRTS	R: On the beals of a					29c. LIC		time, data and place,	and due to the	cause(a) ar	onth, Day, Year)	

D-30035 3/16/93

PERSON WHO COMPLETED CAUSE OF OEATN (ITEM 27) (Type, Print) Oakland-Deer Park Road, Oakland, MD

Dr. Donald Richter,
31. DATE FILEO (Month, Day, Year)
MAR 1 6 1993 32. REGISTRAR'S SIGNATURE

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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Thomas Johnson, MD;

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93 08818 FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -REGISTRAR **CERTIFICATE OF DEATH** REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Ruth HOYE March 8 1993 2:15 Р 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year) 8/15/1897 213-12-9235 1 M 2 K F 95 Maryland Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Route 2, Sang Sang Run Road McHenry Garrett 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Garrett McHenry 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Route 2, SAng Run Road 21541 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexicen, Puerio Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 1 X Never Merried 2 Merried BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 8 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elijah Hoye Mary Cornelia Friend 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baxton Hoye Box 317; McHenry, MD 21541 20e, METHOD OF DISPOSITION
1 (X) Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Donetion 5 Other (Specify) Run Cemetery 3/11 McHenry, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Newman Funeral Homes, P.A. <u>Grantsville</u>, <u>Maryland</u> 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart failure. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition phemphigoid resulting in death) years DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (DR AS A CONSEQUENCE DF): reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO high blood pressure COMPLETION DF CAUSE 1 YES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA te 5 Residence 8 - Other (Specify) 27. MANNED OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, atreet, factory, building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner se stated. 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) end manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER

Oakland, Maryland 21550

29d, DATE SIGNED (Month, Day, Year)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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H ATTEN	FE	13 3	

Pages 1, 2, 3 should

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) Gertrude Elizabeth Inscoe 2. DATE OF DEATH 3. TIME OF DEATH GERTRUDE INSCOE 12 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 213-46-9848 87 YRS. 1 - M 2 - F 7-22-05 New York 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Silver Spring Bedford Court Nursing Home Montgomery DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Silver Spring 1 X YES 2 NO FUNERAL 100. STREET AND NUMBER 3701 International Dr. 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20906 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 JNO IF YES, GIVE WAR OR DATES A 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No If yes, specify Cuben, Mexican, Puerto Rican, etc.) RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 1 TES 2 NO Specify: 3 Widowed 4 ☐ Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Frank J. Treis Gertrude Moraway BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 William J. Cumbie 4236 Worcester Dr. Fairfax, Virginia 22032 P 20a. METHOD OF DISPOSITION

1 Street Burlet 2 Cremation 3 Rem
4 Donation 5 Other (Specify) 20b. PLACE AND DATE DF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Tenm Tenm Arlington National 3/17/93 Arlington, Virginia 21. SIGNATURE OF FUNERAL SERVICE LIST examiner 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Md. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. **IMMEDIATE CAUSE (Finel** Onset and Death the disease or condition HORTIC STENOSIS. 3 year resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): CONGESTIVE HEART FAILURE 28 is marked, or Item 23 shows any injury, or other traumatic PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? CROHNS COLITIS 1 TES 2 NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 TES 2 NO ime 5 Aftesidence 8 - Other (Specify) 4 Num 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b, TIME OF 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Natural ВУ 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be 4 Homicide 29s. CERTIFIER

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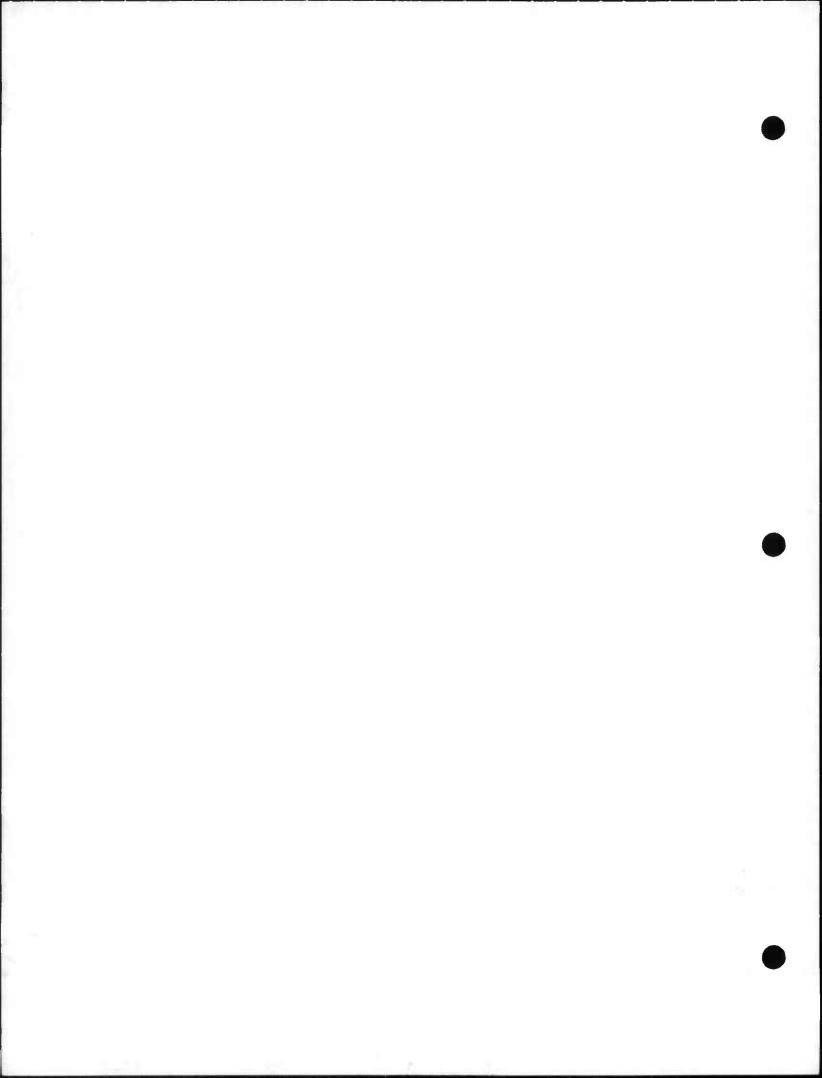
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(C 2 __ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 3-12-93 D24245 comon

SILVER SPRING IMD



MARYLAND 21215-	Dade & may be retained by the bosoital or ottondia
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DIVISION OF VITAL RECORDS, P.O. BOX 6876

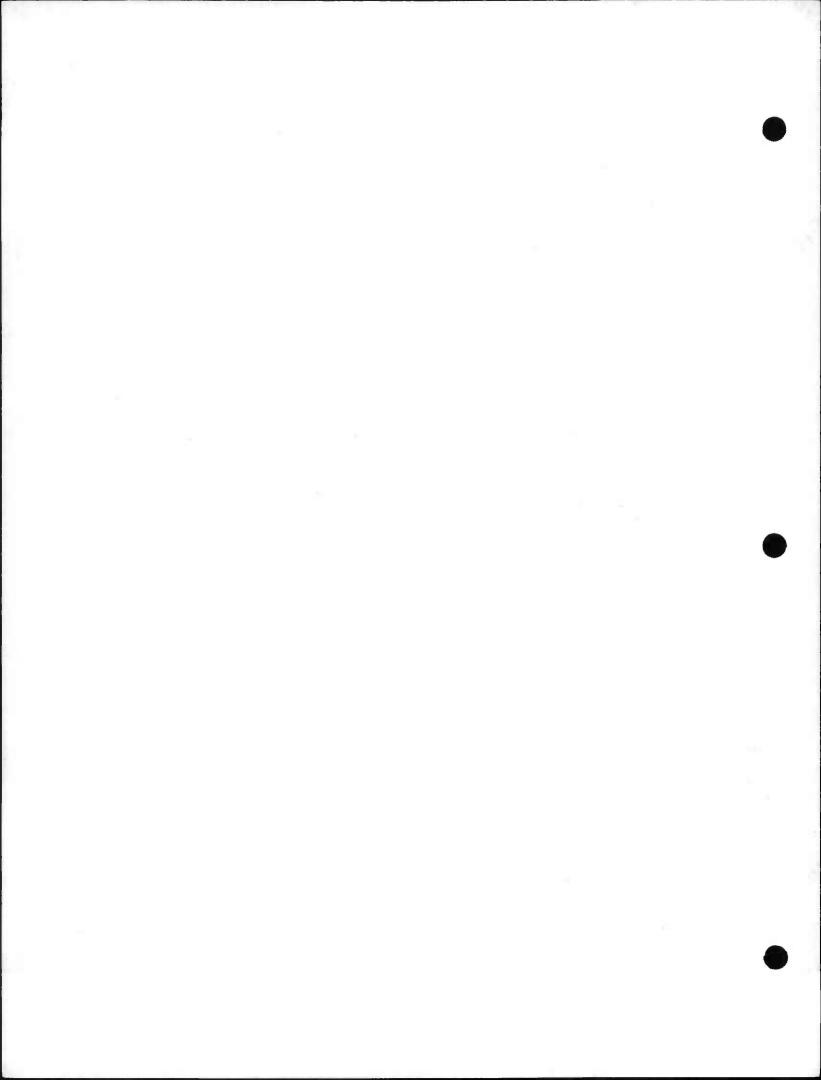
	STATE OF MARY	LAND / DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE
		CERTIFICATE	OF DEATH	REG. NO.
E CT. A ALLER I				

	1 - FOR STATE REGISTRAR	STATE OF MARY		MENT OF H		NTAL HYGIENE		
	1. DECEDENT'S NAME (First, Middle of Control	ISAAC			2	DATE OF DEATH	9"	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 216-44-8933 9a. FACILITY NAME (If not institution	1 M 2 🗆 F	AD ABY	F UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	DATE OF BIRTH (Month, Day, Year) 5-1-1897	N	BHRTHPLACE (State or Foreign Country)
STOR		Medical Center		Annapo	LIS	H 	Anne	Arundel
DIRE		Arne Arundel		TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL D	100. STREET AND NUMBER 186 Campus Gr			101.	21012			OF WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Marr 3 Widowed 4 Divorced	IF YES, GIVE WAR OR	IN U.S. ARMED S 2 NO DATES	13. WAS DEC	ENDENT OF HISPANIC polity Cuban, Mexican, I 2 NO Specify:	ORIGIN? (Specify Yes o Puerto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify: White
once. COMPLETED	15. DECEDEN (Specify only high Elementary/Secondary (0-12)	NT'S EDUCATION Test grade completed) College (1-4 or 5+)	Iffe. Do NOT use	ork done during mos	N st of working	16b. KIND OF BUSI		RY
at once.	17. FATHER'S NAME (First, Middle,	Lest)	NSA		18. MOTHER'S NAME	Federa (First, Middle, Meiden S		
2 2	Walter 194. INFORMANT'S NAME (Type/P		Isaac 196. MAILING	ADDRESS (Street as	Ida nd Number or Rural Rou	ne Number, City or Town,		reen
	Patricia Ruck			-	w Rd. Ann			
E L	1 N Buriel 2 Cremation 3 4 Donation 5 Other (Spec	City)	ob. PLACE AND DATE OF emetery, cremetory or oth Glen Havel	er place) n_Cemete	ry	3/12 Glen		or Town, Stata Le, MD
wal. Si examiner must be	21. SIGNATURE OF PURIETIAL SEC	2 Barre		o essential e es	co Funera	49		chie Hwy. Park MD 21146
event, the medical	23. PART I. Enter the disease shock, or heart IMMEDIATE CAUSE (Final disease or condition resulting in death)	ses, or complications that cause failure. List only one cause on a Dull Ope TO 10R AS	Inte	et enter the mod	de of dying, such a	s cardiac or respir	atory arrest,	Approximate interval Between Onset and Death
i Hygiene prior to buria or other traumatic ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that intilated events resulting in death) LAST	L DUE TO JOH AS	AJCONSEQUENCE OF	ein	alle	ele els		
shows any Inju	PART II. Other significant co	onditions contributing to death	but not resulting in	the underlying	cause given in Pa	24a. WAS AN A PERFORM	NED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
State De Item 2	25. WAS CASE REFERRED TO ME EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:	ACE OF DEATH (Check			
2 2 2	27. MANNER OF DEATH 1 Millural 5 Pend 2 Accident Invest	28a, DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJU	JRY AT 26	Id. DESCRIBE HOW IN	JURY OCCUR	ED
Her de la se del se de la se d	3 Suicide 6 Could	d not be mined 28e. PLACE OF INJUR building, etc. (Sp	RY — At home, farm, streecify)	20	H. LOCATION (Street an City or Town, State)	nd Number or F	lural Route Number,	
2 - 1 -		NG PHYSICIAN: To the best of my kno EXAMINER: On the best of examinet						use(s) and manner se stated.
be filed within 7 IMPORTANT: I	296. SIGNATURE AND TITLE OF	Source !	eps-		DISE	59	29d. DATE SIG	GNED (Morith, Day, Year)
	20. MAME AND ADDRESS OF PER (OO) 1 A G G 21. DATE FILED (Month, Day har)	32. REGISTRAPES STO	HATH OPEN 27) (Type, I	1,0	more	die, 8	TK	2140/
	MAR 1	5 1993 Juha David	cor-Randell	-				/

lie law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

I has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be but of Health and Mental Hygiene prior to burial, cremation, or removal. item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HUSPITAL OR ATTENDIOS PO TO THE FUNERAL DIRECTOR ACCUL De filed within 72 hours after of IMPORTANT: If Item 22 is mark

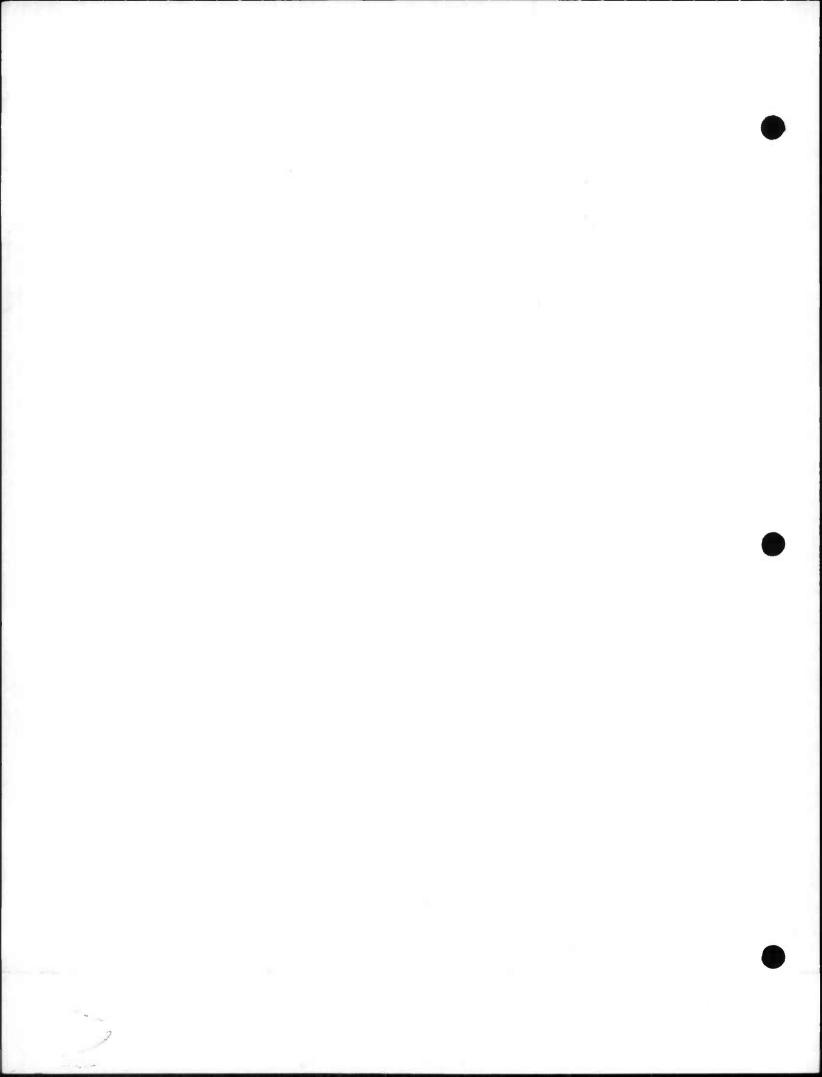
	1 - STATE REGISTRAR	STATE OF MARYLAN		MENT OF H		ENTAL HYGIEN	Ε			
4	1. DECEDENT'S NAME (First, Middle, Last)	OLVATRICE	VATRICE	JIACINT	20	2. DATE OF DEATH	w / ve 1993	ar 2205 M		
	4. SOCIAL SECURITY NUMBER 213-74-4021 98. FACILITY NAME (If not institution, give s	1 □ M 2 😾 F 96	YRS.	7. DATE OF BIRTH (Month, Day, Year) APRIL 18, 1		BIRTHPLACE (State or Foreign Country)				
TOR	SUBURBAN HOSPITAI	All Comment of the Co		BETHES	DA			GOMERY		
DIRECTOR	10a. STATE 10b. COUNT	Y NTGOMERY	TOWN OR LOCAT				10d. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER				ZIP CODE		1 _ YES 2 _ NO			
FUNERAL	10105 DALLAS AVE	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2	S, ARMEO	13. WAS DEC	20901 ENDENT OF NISPANIO	ORIGIN? (Specify Yes	USA or No— 14.	RACE — American Indian, Black, White, etc.		
ВУ	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 TES	2 NO Specify:	Puerto Hican, atc.)		Specify: HITE		
COMPLETED	15. OECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION 164 Completed) College (1-4 or 5+)		SUAL OCCUPATION IN A done during most retired.)	N st of working	16b. KIND OF BUS	SINESS/INDUST	RY		
	17. FATNER'S NAME (First, Middle, Last)	RUCCLERI	1100	DEWILE	16. MOTHER'S NAME PAULINI	E (First, Middle, Meiden	Surname)			
TO BE	19e. INFORMANT'S NAME (Type/Print)	OGENI	19b. MAILING A	DORESS (Street as		ute Number, City or Town		le)		
F	PAULINE F. LONDER			NOWLES		KENSINGTON				
	1 XBuriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	cemetery ROC	ACE AND DATE OF y, crematory or othe CK CREEK	er place)	me of	1	CATION — CRY LINGTON			
	21. SIGNATURE OF PUNERAL SERVICE LI	969		FRANC 500 UN	IVERSITY	LINS FUNE BLVDW.	CRAL HO	ME, INC.		
	23. PART I. Enter the diseases, or shock, or heart failure	complications that caused the List only one cause on each	e death. Do not	t enter the mod	de of dying, such	as cardiac or respi	ratory arrest,	Approximate Interval Between		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	USE (Final dittion) FPTICEM (A)								
_		DUE TO (OR AS A CO	M. O	NIA				2 Warks		
CATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	ading to immediate inter UNDERLYING FRED RAI INFERENCE OF:								
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST		NSEQUENCE OF):	A THE	•	EROS L	5	20 YEARS		
	PART il. Other significant condition	a contributing to death but n					AUTOPSY	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO		
PHYSICIAN: MEDICAL	HYPER.	TENSION				1 YES 2	1	COMPLETION OF CAUSE OF DEATN?		
AN: N								1 Tes 2 No		
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatier		THER:	ACE OF DEATN (Check					
PHY	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c. INJU	JRY AT 2	26d. DESCRIBE NOW IN	JURY OCCURE	О		
ED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	vestigation " 1 YES 2 NO 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 27								
COMPLETED		CIAN: To the best of my knowledge								
	2 MEDICAL EXAMINE 29b, SIGNATURE AND WILE OF CENTIFIES	R: On the basis of examination and	d/or investigation,	In my opinion, de						
TO BE	neph 11	Churco 1	MB		D-020	47	► Mar	ch/2,1993		
	30/NAME AND ADDRESS OF PERSON WH	ONN OR MA	~ 110		ORGETO	WN R	BE	THESOA, MO 20814		
Ì	31. DATE FILED (Month, Day, Year)	32. RESISTRAR'S SIGNATURE DAVIDOR	RE L				-			



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DIVISION OF VITAL	-
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FOR STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) WILLIAM JI Jefferson 2. DATE OF DEATH 3. TIME OF DEATH **JEFFERSON** YEAR 9:55Pm William 93 3 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 229-48-11 1 X4 2 F 4 VIRGINIA use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, giv 9b. CITY, TOWN OR LOCATION OF DEATH C. COUNTY OF DEATH E. IND ONTGOMERY DIRECTOR MESIDENOE OF DECEDENT 10b. COUNTY LIMITS? 10c. CITY, TOWN OR LOCATION Montgomery 1 Syes 2 Mo FUNERAL WHAT COUNTRY? 4 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEMENT, EVER IN U.S. ARMED FORCES? 14 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-2 M If yes, specify Cube
1 ☐ YES 2 ☐ NO 1 Never Married IF YES, GIVE WAR OR DATES Specify BY BLACK COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRO (Specify only highest grade comp ğ Elementary/Secondary (0-12) College (1-4 or 5+) detached 5+ DIRECTOR OF CETA STATE OF MARYLAND 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ page 5 should be PAUL **JEFFERSON** FRANCES notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20901 2 CLARICE WILLIS 524 INDIAN SPRING DRIVE SILVER SPRING, MARYLAND 90 20b. PLACE AND DATE OF DISPOSITION (Name of GREENSVILLE COUNTY VIRGINIA must director. JEFFERSON FAMILY CEMETERY examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE FRANCIS J. COLLINS FUNERAL HOME, INC funeral 500 UNIVERSITY BLVD., W. SIL.SPR., MD.20901 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/Liet only one cause on each line. filled in by Approximate interval Betwe 0 IMMEDIATE CAUSE (Final completely filled rial, cremation, o Onset and Death traumatic event, the disease or condition_ Cardio-respirator arrest resulting in death) executed within DUE TO (OR AS A CONSEQUENCE OF) burial, Metastasis Brain CERTIFICATION attending physician and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING 0 Concer CAUSE (Disease or injury other DUE TO (DR AS A CONSEQUENCE OF that initiated events resulting in death) LAST 6 DIRECTOR: After this certificate has been signed by the hours after death with the State Dept. of Health and Me PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL Arlen Disease shows any Corono 1 TYES 2 NO OF DEATH? Chroni Pulmonny Disease -1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem EXAMINER? HOSPITAL OTHER: 1 TES 2 TO NO Inpatient 2 - ER/Outpatient 3 - DOA ne 5 🗆 Residence 8 🗆 Other (Specify) 4 - Nurs 10 27. MANNER OF DEATH 28e. DATE DF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural 5 Pending 1 YES 2 NO ВУ 2 Accident OR ATTENDING 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 28 Item 29a. CERTIFIER
1 Grant only
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. TO THE HOSPITAL IN THE FUNERAL C DE SING WITHIN 72 ht IMPORTANT: If IN 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 1)37891 3.17.93 10 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Silverspring Ave # 302 MD-20902 A RAJVANSMI MO Georgia 10313 32. REGISTRAR'S SIGNATURE Day. **'9**3 who Davidson

Randell



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be rescuined within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

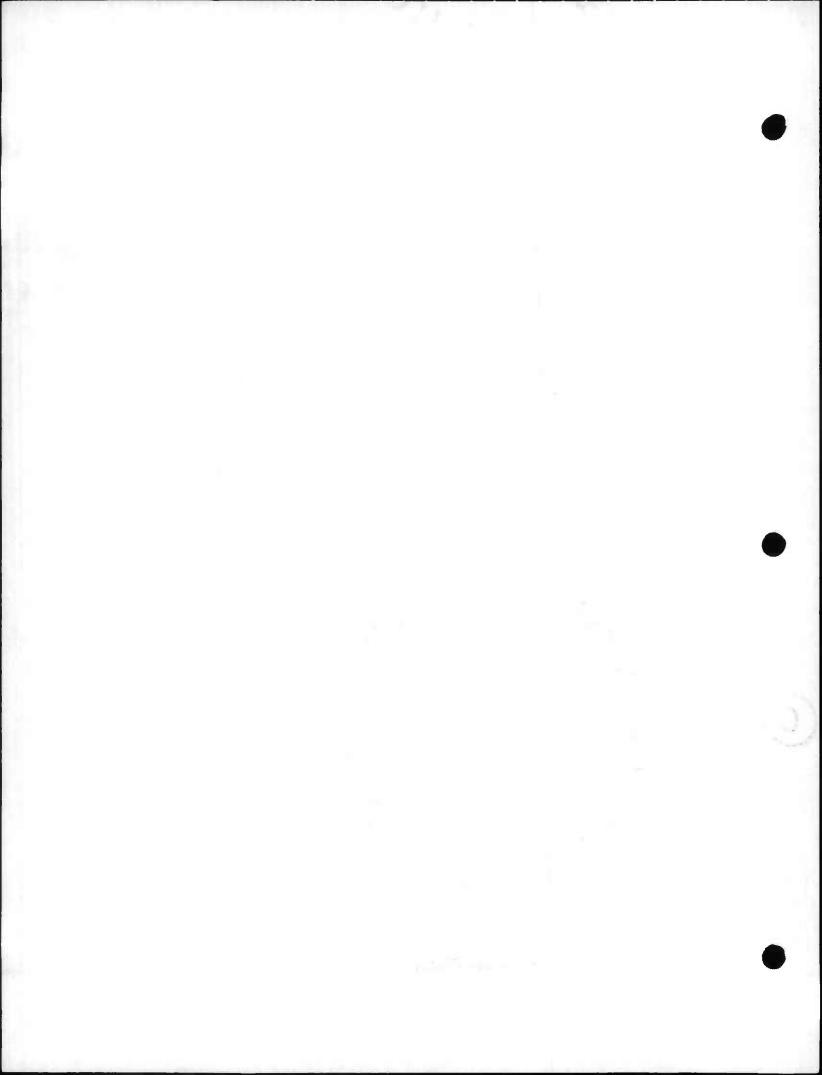
TO THE FUNERAL DIFICION: After this certificate has been aloned by the attending physician and computerly filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after the state Duty of Health and Mental Hydron prior to translation, or removal.

IMPORTANT: If them 28 is marked, or them 23 shows any intury, or other transmatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

L RECORDS, P.O. BOX 68760, DIVISION OF VIT

FOR STATE REGISTRAR									
1. DECEDENT'S NAME (Fir								

9	1. DECEDENT'S NAME (First, Middle, Last)									TE OF DEATH			3. TIME OF DEATH	
0	EMILIO J. JONES DAY									YEAR	10 40 P M			
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR										04 1993 111		
1	The state of the s		8. AGE (In yrs. la	MODERAL DAVE MOLINE NAME (Month, Day, Ye							8. BIRTHPLACE (State or Foreign Country)			
	071-44-0451	1 M 2 F 41 YRS. WONTHS DAYS HOURS WIN. 6-4-5								6-4-51	Panama			
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY.	TOWN C	OR LOCATI	ON OF DE			9c. COI	JNTY OF D		
Œ											""			
2	PRINCE GEORGES	HOSPITA	L CENTER	2			CHE	VERL	Υ			Р	G	
DIRECTOR	10a. STATE 10b. COUNT	~		100 00	Y, TOWN OF		TION.							
2				100.011	i, iown or	N LUCKI	ION						10d, INSIDE CITY LIMITS?	
		nce Georg	es	Во	wie								1 N YES 2 NO	
14	10e. STREET AND NUMBER					101	. ZIP COD	E			10g. CI1	IZEN OF	WHAT COUNTRY?	
FUNERAL	12752 Midwood Lan						207	1.5			D.			
Z	11. MARITAL STATUS	12. WAS DECEDEN										nama		
5	1 Never Married 2 Married		YES 2							GIN? (Specify Yes to Rican, etc.)	s or No-	14. RACI Blac	E — American Indian, k, White, etc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE V	WAR OR DATES					Specify		,		Spec		
	- Indiana - Indiana	<u> </u>										Blac	k	
ETED	15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. DI	CEDENT'S	USUAL OC	CUPATIO	NC		1	6b. KIND OF BU	SINESS/IN	OUSTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5	A)	. Do NOT u	work done de se retired.)	unng mo	IST OF WORK	ng						
김		+2		oc D	epres	ont	otin	0		Compact	T		A	
COMPL	17. FATHER'S NAME (First, Middle, Last)	12	Dai	.cs K	epres	ent	Y	_		Comput		naus	LIY	
5 8							1 = 0 < 20			t, Middle, Maiden	Surname)			
BE	Stanley Jones						P	auli:	ne	Gordon				
	19a. INFORMANT'S NAME (Type/Print)		19	b. MAJLING	ADDRESS	(Street a	ind Numbe	r or Flural F	Route No	imber, City or Tox	m, State, Zi	ip Code)		
임	Pauline Gordon		4	8 St	Рап	110	P12	Ce	Bro	oklyn,	NV	1122	6	
	20a. METHOD OF DISPOSITION		20b. PLACE								CATION -	_		
	1 Duriel 2 Cremation 3 Ran	noval from State	cemetery, cri	ematory or o	ther place)				1					
	4 Donation 5 Other (Specify)		St. C	harl						11/93 F	armi	.ngda	le, NY	
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE						SS OF FAC						
	* Kalunt C	6 Iran	n Pa	1	l B	eal	1-Ev	ans	Fun	eral Ho	me			
	110000	Court	2,110	12	1	600	U An	napo.	lis	Road	Bowi	e, M	D 20715	
	23. PART i. Enter the diseases, or ahock, or heert fellure.	complications that	it calused the de	eath. Do	not enter t	the mo	de of dy	ing, suct	h as c	ardiac or reap	iratory ar	rreat,	Approximate	
	IMMEDIATE CAUSE (Final							_					Onset and Death	
	disease or condition	Ani	DXIC		SNIC	EP	HAI	O PA	ATI	4 Y				
	disease or condition resulting in death) ANOXIC ENCEPHALO PATHY Due to (or as a consequence of): Due to STATUS EPILEPTICUS													
	II Indiana and a second	DUE TO	OR AS A CONSE	OLIENCE O	D.					1 =0:	1 < 0 =	. 0.110		
	illustration and an arrangement	DUE TO	(OR AS A CONSE	OUENCE O	F):	DUE	ETO) ST	ATU	15 EPI	LEPT	icus		
NO		b 5	EPSIS			DUE	ETO) ST	ATU	15 EPI	LEPT	icus		
VTION	Sequentially list conditions, if any, leading to immediate	b. S	EPS 15			DUE	ETO) ST	ATU	IS EPI	LEPT	icus		
CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b. S. DUE TO	EPS 1S (OR AS A CONSE 1 D S	OUENCE O	F):	DUE	ETO	7 51	ATO	IS EPI	LEPT	icus		
IFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b. Some to DUE to DUE to	EPS 1S (OR AS A CONSE 1 D S (OR AS A CONSE	OUENCE O	F):					IS EPI	LEPT	icus		
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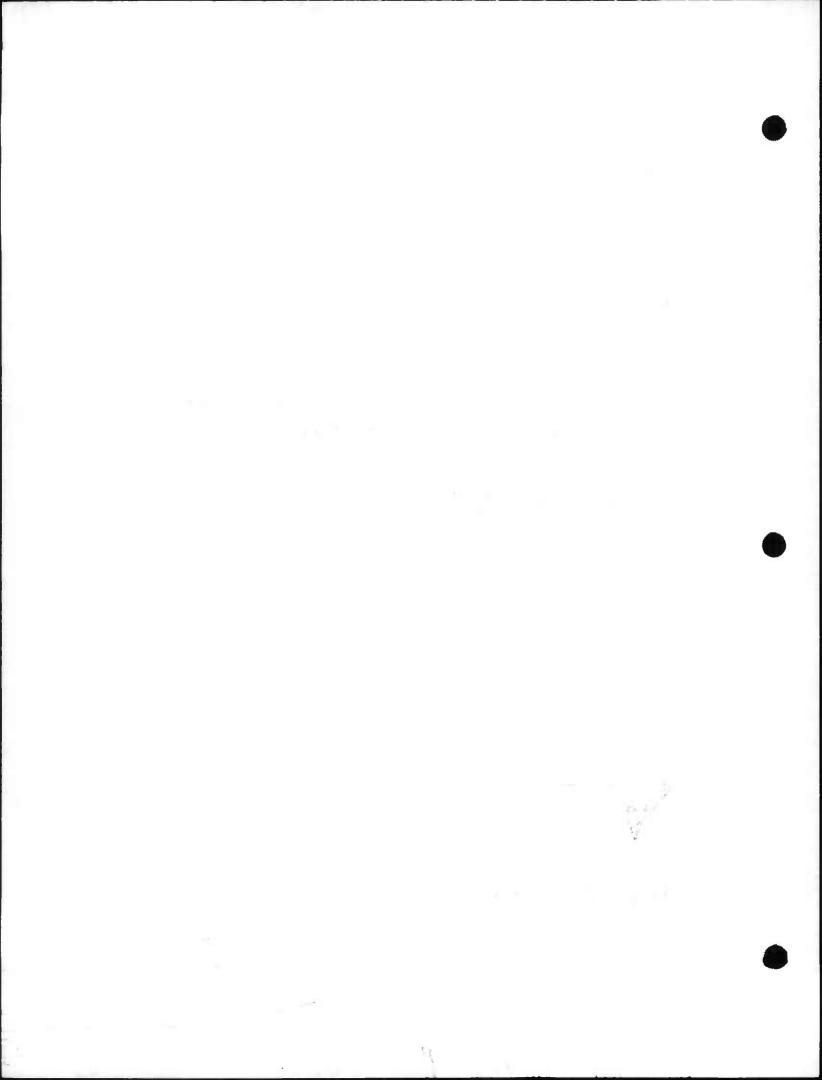
1,27, per MEO, G-698, 4/2/93 gn STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIEN

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		1. DECEDENT'S NAME (First, Middle, Las	0						2. DATE OF DEATH		3. TIME OF DEATH	
,		Falecia	M		Joh	nson			MONTH D.		93 0750 M	
	li	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (in yrs. les		IF UNDER 1 YE	EAR IF UNDER S	24124	7. DATE OF BIRTH (Month, Day, Year)	1	BIRTHPLACE (State or Foreign Country)	
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3 should	oc	9e. FACILITY NAME (if not institution, give				9b. CITY, TO	WN OR LOCATIO	N OF DEA	TN	9c. COUNT	Y OF DEATH	
1. 2, 3	<u>ē</u>	Doctor's Community Hospital Lanham Prince Geor										
	DIRECTOR	10e. STATE 10b. COUN			7	Y, TOWN OR L	OCATION				10d. INSIDE CITY	
₹. 2.		Maryland Prin]]	Bowie					LIMITS?			
E e	₹	10e. STREET AND NUMBER			101. ZIP CODE			10g. CITIZE	N OF WHAT COUNTRY?			
physician. burial-transit permit. Pages	FUNERAL	12705 Buckingham					2071.	5		Unit	ed States	
nysicia urial-t		11. MARITAL STATUS 1. Service Married 2 Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AR	MED	13. WAS	DECENOENT OF	NISPANI Mexicen	C ORIGIN? (Specify Yes Puerto Rican, etc.)	or No- 1	4. RACE — American Indian, Black, White, etc.	
B ag	a l	3 Widowed 4 Divorced	IF YES, GIVE W	WAR OR DATES	No		YES ZYNO	Specify:	No		Specify:	
or attending physician.		15, OECEDENT'S ED	UCATION	16a, DE	CEDENT'S	USUAL OCCU	PATION		16b. KIND OF BUS	SINESS/INOUS	STRY	
_ 3	Щ	(Specify only highest gra- Elementary/Secondary (0-12)	College (1-4 or 5 a		ive kind of Do NOT u	work done durin se retired.)	ng most of working					
the hospital or detached for u once.	필											
by the hospital of the detached for at once.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTNE	R'S NAM	E (First, Middle, Maiden	Sumame)		
ad by	BE	Ronald S. Babbi	tt				Li	sa O	. Johnson			
5 should notified	2	19a, INFORMANT'S NAME (Type/Print)		- 1					oute Number, City or Tow		<i>'</i>	
may be or, page to		Ronald S. Babbit	<u>t</u>					Driv	e Bowie M			
9 5 6		1X Buriel 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	cometery, cre	metory or o	of Dispositio	N/Name of Cemeter	. 2	1		ty or Town, State	
Page al dire		21. SIGNATURE OF FUNERAL SERVICE I	ICENSEE	Rest	illec	22. NAM	E AND ADDRESS	OF FACI	LITY		Maryland	
death. Pag tuneral di l. examiner		Beall-Evans Funeral Home, P.A.										
n by the removal.		23. PART I. Enter the diseeses, DI	complications the	2 11 WE	ath Do	160	000 Anna	ipol	is Rd. Boy	vie Ma	ryland 20715	
24 hours filled in ion, or n		shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	Sudde	n unex	plai	ned i				retory arres	t, Approximate Interval Between Onset and Death	
th certificate be ending physicia I Hygiene prior or other trau	CERTIFICATION	Sequentially list conditione, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.										
een signe of Healt	MEDICAL	PART II. Other significent condition	ns contributing to	death but not n	eeulting	in the under	lying cause gl	ven in P	art I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
	AN	25. WAS CASE REFERRED TO MEDICAL	Т				a Di ace or on	TN 274	t only on-1			
DR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has brours after death with the State Dept tem 28 is marked, or flem 23	SICIAN	EXAMINER?	HOSPITAL:	EB/Outpations 3	□ po±	OTHER:	6. PLACE OF DE		, , , ,			
SICIA certif	PHYS	27. MANNER OF OEATH	28e. DATE OF	INJURY	28b. TIM		Home 5 Resi		Other (Specify) 28d, DESCRIBE HOW II	UJOOO YRULK	RED	
NG PHYSI fer this c eath with marked,	- 40	1 Netural Periamy	(Month, De	ay, Year)	INJ	URY	WORK?					
NDING I: After r death is mai	D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE O	F INJURY — At horetc. (Specify)	me, term,	street, factory,	office		281. LOCATION (Street a	ind Number or	Rural Route Number,	
DR ATTENDING DIRECTOR: After nours after death tem 28 is ma		4 Nomicide determined	ounding,	ette (apacity)					City or Town, State)			
	COMPLETED	29e. CERTIFIER (Check only 1 CERTIFYING PNY	SICIAN: To the best of	my knowledge, de:	eth occum	ed at the time,	date end place, e	nd due to	the ceuse(a) and man	ner ea stated		
1 10	O O										cause(e) and menner as stated.	
533	ш	29b. SIGNATURE AND TITLE OF CERTIFI	f/ 0.0				29c. LICEN	SE NUME	ER	29d, DATE S	SIGNED (Month, Day, Year)	
2018	9 0	Mayore Vorel	full				0	. C.1	M.E.	▶ 02	26 1993	
	F	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUS	SE OF DEATH (ITEM	1 27) (Type,	Print)				· VA		
		Margarita A.	Korell.	MD.11	1 Pe	enn Si	reet.	_Ba	ltimore.	Mars	zland 21201	
į.		MAR () (1002	32. REGISTRA	R'S SIGNATURE								

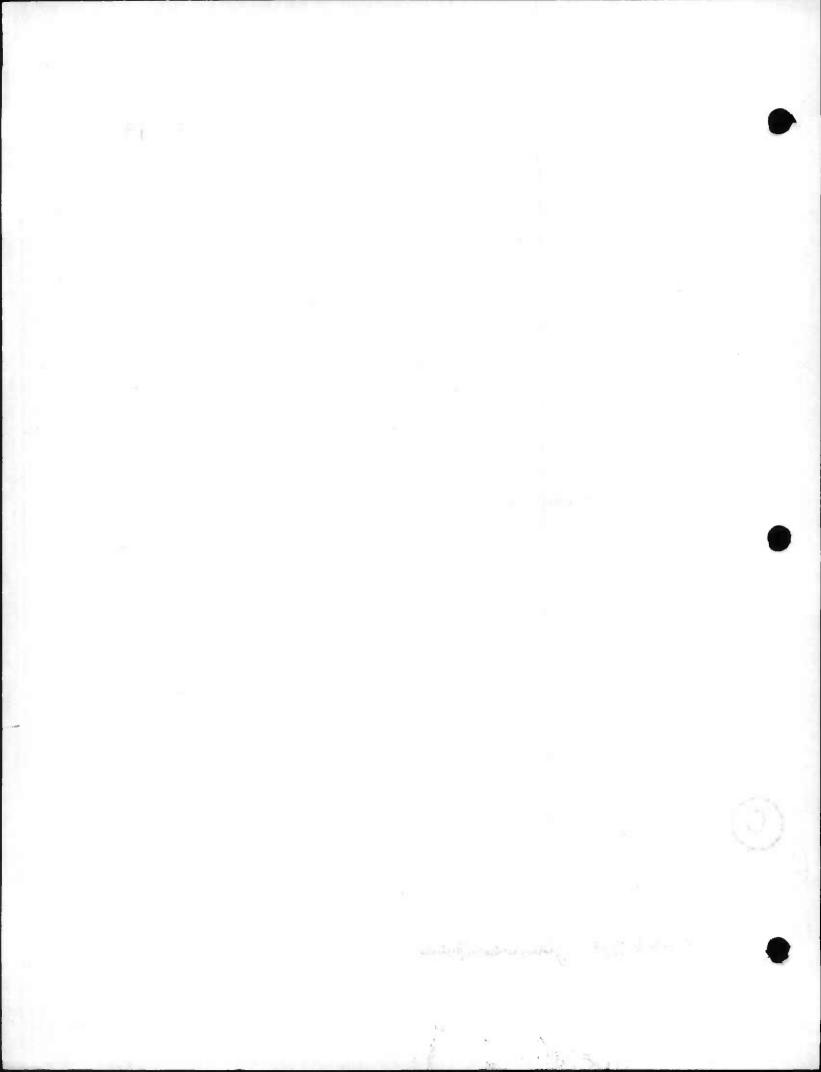
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020



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MINGION OF VITAL RECORDS, P.O. BOX 6876	pertending PHYSICIAN; The law requires that the death certificate be executed w	TO THE FUNDAL RECOVER WHITE WAS WAITIFICATE has been signed by the attending physician and comp	buris	IMPORTANT: Interest is marked, or item 23 shows any injury, or other traumatic eve
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	REGISTRAR CERTIFICATE OF DEAT	TH	REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)		TE OF DEATN		3. TIME OF DEATN			
	OTIC TOILCO	MQI	3 6	08	620			
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER	7 200	E OF BIRTH					
	The state of the s	MIN. (MG	onth, Day, Year)		TTHPLACE (State or Foreign untry)			
	147-64-6278 17 M 2 D F 23 YRS. MONTHS DAYS HOURS	4	- 21 - LS	PLU	ACH IC			
	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATE			9c. COUNTY OF	DEATN			
E	1 dellisator manina R di salas m	m or	730	OA				
K	RESIDENCE OF DECEDENT	ITV OV	170	16				
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY			
뜻	Maryland Prince George's Marningcia	10			LIMITS?			
		ae_			YES 2 NO			
FUNERAL	10- STREET AND NUMBER	E		10g. CITIZEN O	F WHAT COUNTRY?			
	6106 Flmendort Drive 20	5746		O.	S. H.			
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF	OF HISPANIC ORIG	GIN? (Specify Yes	or No- 14. R/	ACE — American Indian,			
	1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Cuba IF YES, GIVE WAR OR OATES 1 YES 2 NO		lo Rican, stc.)		ack, White, atc.			
B	3 Widowed 4 Divorced	apoeny.		- Sp	echy: Black			
C	15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION	1	6b. KIND OF BUS	INESS/INDUSTRY	0,00,1			
	(Specify only highest grade completed) (Give kind of work done during most of working the De NOT use whiteful	ng						
7	Elementary/Secondary (0-12) College (1-4 or 5+)		5	0 -	- mico			
Σ	102 Dailer				SULLE			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	HER'S NAME (Firs	t, Middle, Malden S	Surname)				
BE	John H. Jackson E	lain	e (-	grad :	ner			
	19a, INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street and Number	r or Rural Route Nu	imber, City or Town	, State, Zio Code)				
5	1 - 2012 (202 Y - doz	7 2 -		1	MC 202)16			
	29a_METHOD OF DISPOSITION 20b PLACE AND DATE OF DISPOSITION (Name of	ort 1		crnside				
	1 Burial 2 Cremation 3 Removal from State			CATION — City or	Town, Stata			
	4 Donation 6 Other (Specify) Harmony Conche	ery 13	18 4	andov	er mu			
	21, SIGNATURE OF FUNERAL SERVICE LICENSEE				,			
	Alexande							
	(1) 10 10 5538 Mar	lboro P	K, Dist	rict Hg	ts., MD 20747			
	23. PART I. Enter the diseases, or complications that caused the death, Do not enter the mode of dyl shock, or heart failure. Liet only one cause on each line.	ing, such as ca	ardiac or reapir	ratory arrest,	Approximata			
	iMMEDIATE CAUSE (Finel				Interval Between Onset and Deeth			
	disease or condition Contri coming							
	resulting in death) . Septicemia							
	DUE TO (OR AS A CONSEQUENCE OF):							
ᅎᅵ	Sequentisity list conditions, Brain Tumor							
CERTIFICATION	If any, leading to immediate							
3	cause. Enter UNDERLYING CAUSE (Disease or injury							
	that initiated events DUE TO (OR AS A CONSEQUENCE OF):							
	resulting in death) LAST Acquired Immune Deficiency Syn	drome						
ᄬᅵ								
	PART II. Other significant conditions contributing to deeth but not recuiting in the underlying ceuse of	given in Part i.	24a, WAS AN		4b. WERE AUTOPSY FINDINGS			
DICAL			PERFORI	N	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
			1 TES 2	No	OF DEATH?			
PHYSICIAN: ME					1 TYES 2 NO			
z								
×۱		EATH (Check only	one)					
ဗ္ဗ၂	HOSPITAL: 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA A Nursing Nome 5 Re	reidence & 🗀 Ot	has (Casaiba)					
<u></u>	27, MANNER OF DEATH 260, DATE OF INJURY 28b, TIME OF 28c, INJURY AT		EŞCRIBE HOW IN	I HIDY OCCUPED				
_	(Month, Day, Year) INJURY WORK?		EQUINDE ITON IN	JOHN OCCORED				
B	2 Accident Investigation M 1 YES 2	NO						
٥	3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, tarm, street, factory, offica building, etc. (Specify)		CATION (Street er ty or Town, State)	nd Number or Run	al Route Number,			
-	4 Nomicide determined							
	29a. CERTIFIER CEPTIEVING PHYSICIAN, To the head of the lead of th							
COMPLETED	(Check only one) CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and place, one)							
Ö	One) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occur	red at the time, de	ita end place, and	dua to the cause	e(s) and manner as stated.			
	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICE	ENSE NUMBER		29d. DATE SIGN	ED (Month, Day, Year)			
BE	V. No O Mrs			▶ 03/0				
2	30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)			200/0	0/73			
		0	- 6 A		1 00			
	Khosrow Davachi, mo 1328 Southern	HUE,	2514	W 60%	oshi UE 20021			
	31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE							
	MAR 0 8 1993 Girle Devidon-Rondole							
					OHMH-16 Rev 1/89			

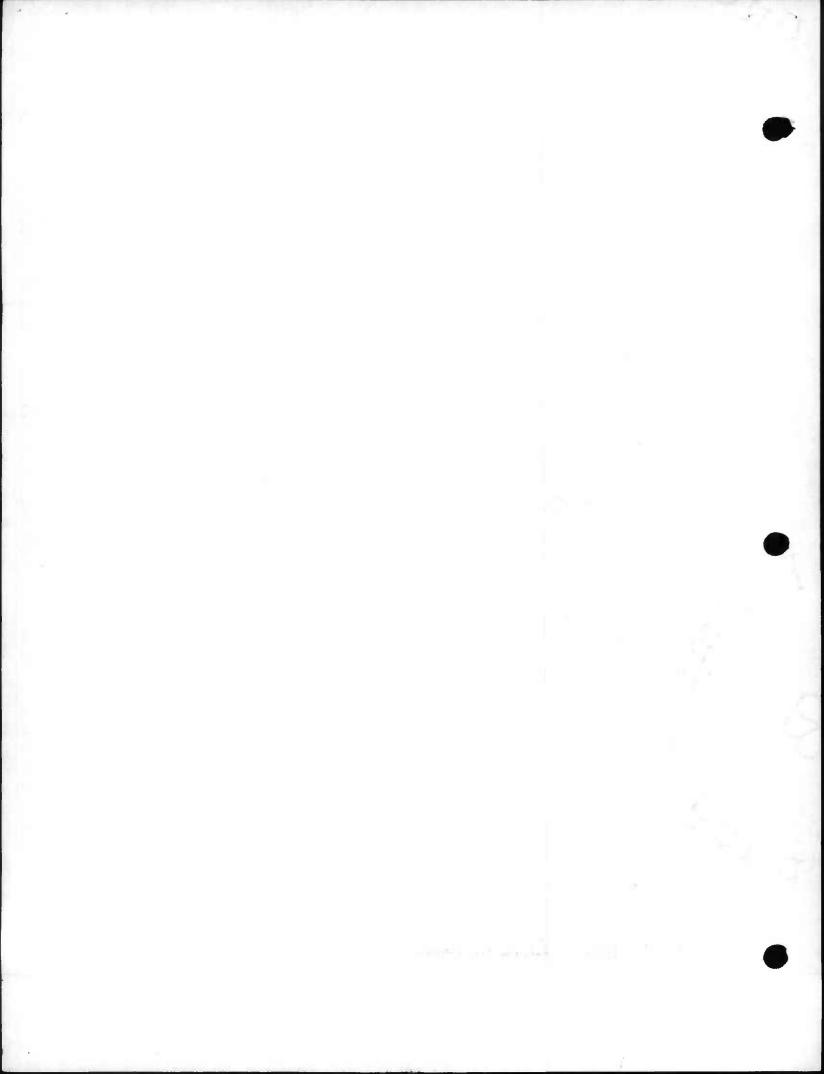


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		the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
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BALTIMORE, MARYLAND 21215-0020	fter death. Page 6 may be retained by the hospital or attending physicia	D D
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	TO THE HOSPITAL OR STEED OF PRYSICIAN. The law requires that the death certificials be executed within 24 hours after death. Page 6 may be retained by the hos	TO THE FLANEWAL DIRECTOR After this certificate has been signed by the amending physician and completely filled in by the funeral director, page 5 should be detach.		IMPORTANT: Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE STATE OF MARYLAN	D / DEPARTI CERTIFIC			MENTAL HYGIEN REG. NO			
1	1. DECEDENT'S NAME (First, Middle, Lest)	TONTEG			2. DATE OF OEATH MONTH D	AY YE	3. TIME OF DEATH	
	W & C V	JONES 3. last birthday) II	- 12-22-		2 2	7 9	3 5-15 AM	
	577 - 60 - 8624 1 M 2 F 49 90. FACILITY NAME (If not institution, give street and number)	YRS. M	F UNDER 1 YEAR DNTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	44 '	SIRTHPLACE (State or Foreign Country) Mzy/z~d	
TOR	Mercy Medical Conte		BUX	mure	EATH	9c. COUNTY	Settmare City	
DIRECTOR	Mry/mol Bellmore		lymor			-	10d. INSIDE CITY LIMITS? YES 2 NO	
FUNERAL	100. STREET AND NUMBER	Destin	101	2/23	()	10g. CITIZEN	OF WHAT COUNTRY?	
┢	11. MARITAL STATUS Never Married 2 Married 3 Widowed 4 Divorced If YES, GIVE WAR OR DATE:	NO	If yes, sp	ENDENT OF HISPA	NIC ORIGIN? (Specify Yer in, Puerto Rican, etc.)		RACE — American Indian, Black, Whits, etc. Specify: BLACK	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	Give kind of work	BUAL OCCUPATION Money of the done during money of the during money	ON st of working	16b. KIND OF BU	SINESS/INDUST		
MP	UNK UNK	SHOE SA	ALESMAN			PRIVA	TE	
BE CO	17. FATHER'S NAME (First, Middle, Last) UNK				E. JONES	Surname)	JB	
2	19s. INFORMANT'S NAME (Type/Print)				Route Number, City or Tow	,,	(0)	
	MELINDA GLADNEY 208, METHOD OF DISPOSITION 20b, PL	1 1424 CI			OATE 20c, LO	009 CATION — City	or Town, State	
	1 X Burisi 2 Cremation 3 Removal from State cemeter	y, crematory or other MONY MEN	place)		1		MARYLAND	
1	21. SIGNATURE OF FUNERAL SERVICE CICENSEE	æ			edy Str	overa		
	23. PART I. Enter the diseases, or complications that caused the shock, or heart fellure. List only one cause on each iMMEDIATE CAUSE (Finel disease or condition resulting in death) a	iine.	4	de of dying, suc	th as cardiec or respi	ratory arrest,	Approximate interval Between Onset and Deat	
CENTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. UNE TO (OR AS A CONSEQUENCE OF): C. Premman C. DUE TO (OR AS A CONSEQUENCE OF): d. Japan Consequence OF):							
MEDICAL	PART II. Other significant conditions contributing to deeth but i	not resulting in	the underlying	g ceuse given in	Part I. 24a. WAS AN PERFOR	IMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		28, PL	ACE OF OEATH (C)	eck only one!			
300	EXAMINER? 1 YES 2 NO 1 Ippetient 2 ER/Outpetie		THER:		8 Other (Specify)			
BY PHY	27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, Year) Accident Investigation	28b. TIME O	OF 28c. INJ Y WO		28d. OESCRIBE HOW I	NJURY OCCURE	ED	
	Accident investigation Suicide 8 Could not be determined 28e. PLACE OF INJURY — i building, etc. (Specify)	At home, ferm, stre	et, factory, offic		281, LOCATION (Street and City or Town, State)	and Number or R	lural Route Number,	
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge one) 2 MEDICAL EXAMINER: On the basis of examination an						use(s) and menner as stated.	
#	SUMMER AND TITLE OF CENTIFIES			29c. LICENSE NU			7753	
2	30, NAME AND ADDRESS OF PERSON WYO COMPLETED GAUSE OF DEATH	OTEM 27) Glype, Pri	(nt)		4 2	-	1111	
1	SI, DATE FILED (Movin), Day, Year)	RE .					18	
	MAK 1 0 1993 Julia Davidson-Rono	tell						



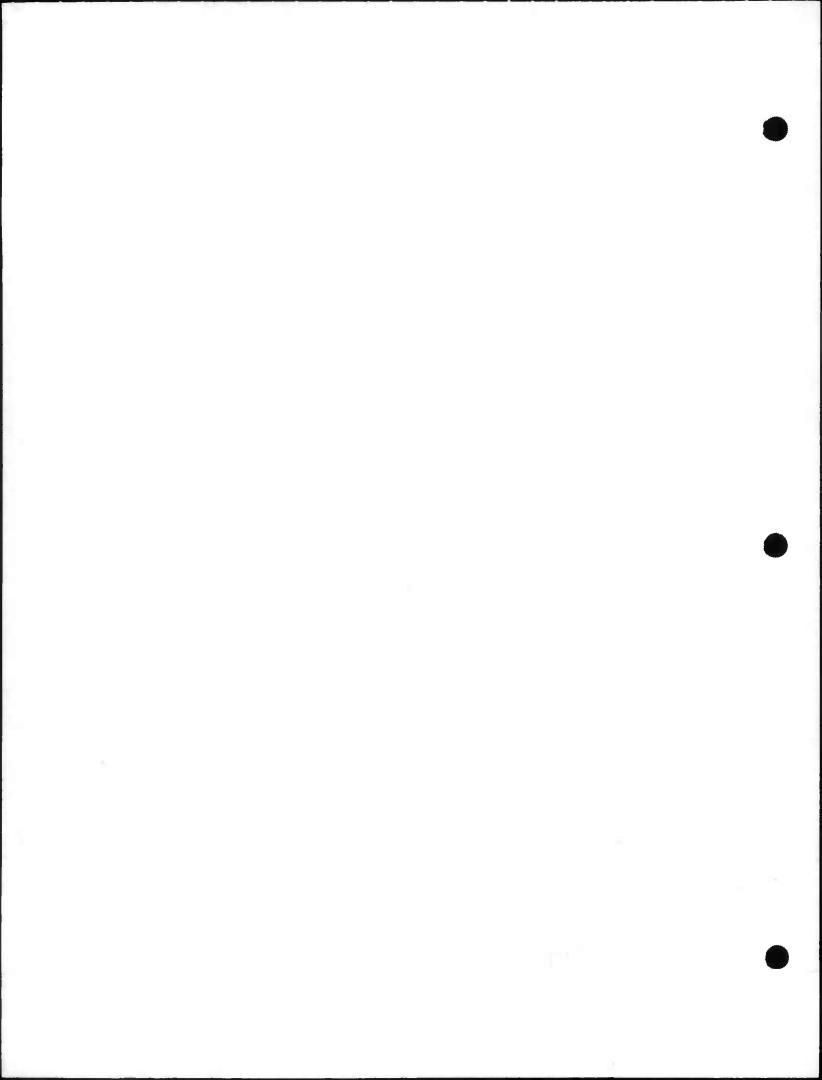
DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should shown after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. LION ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICATE OF DEATH REG. NO.										
100000	1. DECEDENT'S NAME (First, Middle, Lest)	JACK	SON				2, DATE OF	_		93 ^{AR}	3. TIME OF DEATH 12:00 A _M
	4. SOCIAL SECURITY NUMBER 217-76-5861	1 □ M 2XXF	AGE (In yrs. lest bir	YRS.	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, De DECEM	nc Year)		13	PLACE (State or Foreign VIRGINIA
TOR	an. FACILITY NAME (If not institution, give a NORTH ARUNDEL HOS RESIDENCE OF DECEDENT		OCIATION	9		EN BURNIE				.A. (COUNTY
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND	Y	10		OWN OR LOCAL						10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER			WIL		H, ZIP CODE			10g. CITI		1 YES 2 NO HAT COUNTRY?
FUNERAL	P.O. BOX				2167 U.S.A.						
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wyldowed 4 Divorced	12. WAS DECEDENT I FORCES? 1 _ IF YES, GIVE WAR	YES 2 XNO	•	If yes, sp	CENDENT OF HISPAI Decify Cuben, Maxica S 2 NO Specif	in, Puarto Rica	pecify Yes n, etc.)	or No-	14. RACE Black, Specific BLAC	— American Indian, White, etc.
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give k	ENT'S US sind of work NOT use re)MEST		ON ost of working	16b. KIN	ID OF BUS	SINESS/IND	USTRY	
SOM	17. FATHER'S NAME (First, Middle, Last)	COM				18. MOTHER'S NA	ME_(First, Midd	le, Maiden	Sumame)		
BE	JAMES JACKS 19a. INFORMANT'S NAME (Type/Print)	50N	401.40	44 440 45	22500 (0)						
임	PAT WILSON		CRO	WNSV	ILLE H	and Number or Rural OSPITAL	CENTER	, CR	dwnst	TLE	, MD. 21032
	20e. METHOD OF DISPOSITION 1 Buriel 2 Kömmation 3 Rem 4 Donation 5 Other (Specify)		206. PLACE AND			ame of	DATE 20c. LOCATION — City or Town, State BALTIMORE, MD.				
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE Page 1			REESE	ND ADDRESS OF FA	MORTUA			2140	1
-	23. PART I. Enter the diseases, or cehock, or heart failure.	emplications that c	eused the deeth.	. Do not							Approximate interval Between
	IMMEDIATE CAUSE (Fine) Onset end Death										
	resulting in deeth) e. CAND AN 1557 DUE TO (OR AS A CONSEQUENCE OF):										
NO	Sequentially list conditions, If any, leading to immediate b. Physics Count Control C										
CERTIFICATION	CAUSE (Disease or injury C. DIM BULIC BCIDOS)										
BITI	that initiated events resulting in death) LAST	d	AS A CONSEQUE	NCE OF):			,				
N C	PART II. Other algnificent condition	s contributing to de	eath but not reeu	Iting in t	the underlyin	g ceuse given in	Part I. 24a	. WAS AN			WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL							10	PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
. ME							_				1 TYES 2 NO
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				LACE OF DEATH (Ch	eck only one)				
14Si	1 YES 2 NO 27. MANNER OF DEATH	Inpetient 2 - E		DOA 4		ne 5 🗆 Rasidenca					4
BY PF	1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF IN. (Month, Day,	Year) 28	INJURY	Y WC	URY AT ORK? YES 2 NO	28d. DESCRII	BE HOW IN	JURY OCC	URED	
	2 Accident 3 Suicide 8 Could not be detarmined 4 Homicide 28a. PLACE OF INJURY — A1 homa, 1arm, streat, 1actory, office building, etc. (Specify) 28a. PLACE OF INJURY — A1 homa, 1arm, streat, 1actory, office City or Town, State)						oute Number,				
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MPDICAL EXAMINE	CIAN: To the best of my	knowledge, death on nination and/or inves	occurred a	nt the time, data	and place, and due leath occured at the	to the cause(s) and man place, and	ner as state	ed. cause(s)	and manner as stated.
BE	296. SIGNATURE AND TITLE OF CONTINER					29c. LICENSE NUN	MBER		29d. DATE	SIGNED (Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WHO					17778	<u> 38</u>	010	00	/_	W7 5
	JOHN SHAVERS, M.I.		CAMP ME	ADE	RD. L	INTHICUM	, MD.	210	90		
	31. DATE FILED (MONTH, Day, Year) MAR 1 6 1993 Juha Saydson Asnder										



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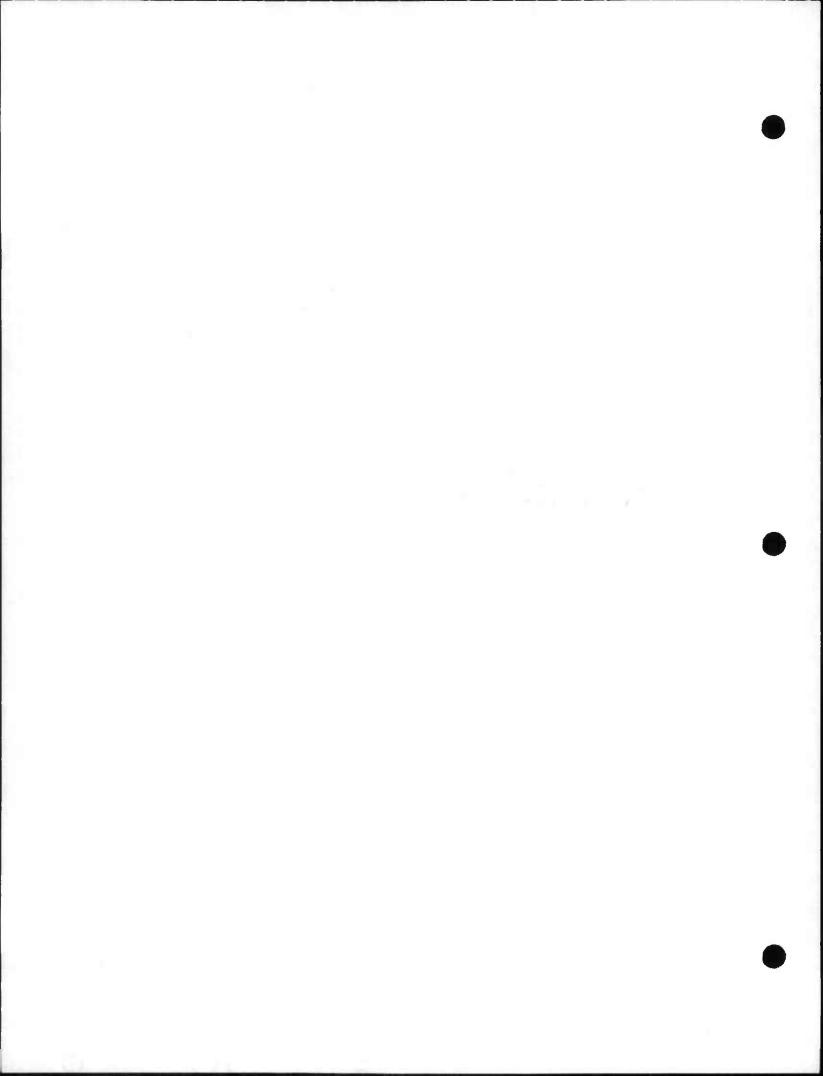
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CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH Sally Cathell YEAR Jump 3 93 4:00 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Maryland aroline 1 M 2 F YRS. 222-14-9961 8-2-1897 use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF GEATH DIRECTOR Meridian Nursing Center - The Pines Easton, MD 21601 Talbot 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Caroline Denton 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Greensboro Road U.S.A. 21629 executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, and completely filled in by the funeral director, page 5 should be detached for use as the burlal-trans to burial, cremation, or removal. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, Whits, etc. 1 Never Married 2 Married IF YES. GIVE WAR OR DATES 1 TES 2 NO Specify: В 3 Widowed 4 Divorced Caucasian COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 12 yrs. Homemaker Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 10 Dr. James Hoskins Ward Coates Ida notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 James W. Jump 5412 Morning Glory Ct., Columbia, Maryland 21044 9 20a. METHOD OF DISPOSITION

1 Burlal 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must Denton Cemetery 3/20 Denton, Maryland 4 Donation 5 Other (Specify) 21. SUBSATURE OF FO examiner 22. NAME AND ADDRESS OF FACILITY Moore Funeral Home, P.A. Drawer B, Denton, Maryland 21629 medical 23. PART i. Enter the diseases, Enter the diseases, of complications that caused the des shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, **Approximate** interval Betw IMMEDIATE CAUSE (Final Onset and Death traumatic event, the disease or condition NEUTIONIA resulting in death) OUE TO (OR AS A CONSEQUENCE OF) the attending physician and con Mental Hygiene prior to burial, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING 2 death certificate CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 Injury, DIRECTOR: After this certificate has been signed by the hours after death with the State Dept, of Health and Me PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS law requires that the MAILABLE PRIOR TO COMPLETION OF CAUSE 23 shows any 1 - YES 2 100 1 - YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) The llem HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO THE HISPITAL OR ATTENDING PHYSICIAN: THE THE TANK OF RECTOR: After this certifical filed within 72 hours after death with the Sta Hursing Home 5 ☐ Residence 8 ☐ Other (Specify) 0 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF INJURY marked, 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident TO THE POSPITATION ATTENDING TO THE PARTY After the field within 72 hours after deat IMPORTANT: If item 28 is m 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homicide 29s. CERTIFIER (Check only one) 2 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placs, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Frain M 100 250 3 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C.RW BAIN 5-DOVER 31. DATE FILED (Month, Day, Year)
MAR 1 9 93 32. REGISTRAR'S SIGNATURE

a Davidson-Randale

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



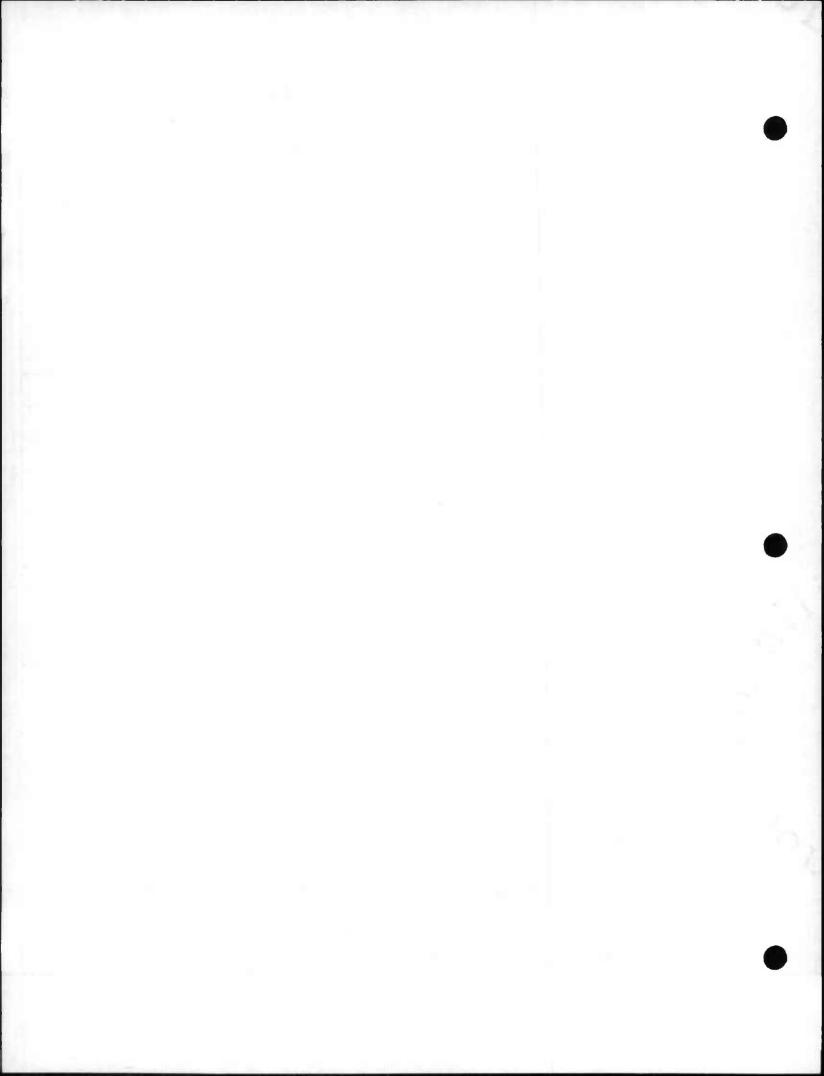
TOTHE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TOTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE	0F	MARYLAND /	DEPARTMENT	0F	HEALTH AN	ID MENTAL	HYGIENE
		C	ERTIFICATE	O	F DEATH		REG NO

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGI	ENE	3 00023	
	1. DECEDENT'S NAME (First, Middle, Last)	RUTH Eliza	Jones	JONES		2. DATE OF DEATH	DAY	3. TIME OF DEATH 204M	
	4. SOCIAL SECURITY NUMBER 219-44-4555 9a. FACILITY NAME (If not institution, give	1 🗌 M 2 💢 F	(In yrs. lest birthday) 70 vrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN. OR LOCATION OF D	7. DATE OF BIRTH (Month, Day, You Aug. 7, 19	22	BIRTHPLACE (State or Foreign Country) West Virginia	
DIRECTOR	Washington Coun	· · · · · · · · · · · · · · · · · · ·			agerstown		/ .	here I ton	
	Maryland Wash	n ington		agerstov	vn			10d. INSIDE CITY LIMITS? 1)\(\) YES 2 \(\) NO	
FUNERAL	831 Noland Dr.				21740			N OF WHAT COUNTRY?	
B	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES	2 X NO	If yes, sp		NIC ORIGIN? (Specify an, Puerto Rican, etc. fy:)	RACE — American Indian, Black, Whita, etc. Specify: Nhite	
COMPLETED	15. DECEDENT'S ED (Specify only highest gree Elementary/Secondary (0-12)	UCATION te completed) College (1-4 or 5 +)		USUAL OCCUPATION OF PORT HOUSE PROPERTY PROPERTY PROPERT	ON ost of working		BUSINESS/INDUS	СТЯУ	
OM	17. FATHER'S NAME (First, Middle, Last)		110051	ewite	18. MOTHER'S NA	AME (First, Middle, Ma	OME		
BE C	James	William	Bo	yles	Laura	Sus		Walker	
TO B	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or			
F	John L.Jones		831 No	oland Dr	. Hagers	stown,MD	21740		
	20e. METHOD OF DISPOSITION 1X Buriel 2 Cremation 3 Rec 4 Donation 6 Other (Specify)	moval from State	PLACEAND DATEO retery, cremetory or of TEEN LAWN	prosposition (Na ther place) Mem. Par	emeo ok Mar.12	DATE 200 2,1993 Wi	LOCATION — CH 11iamspo	or Town, State	
	21. SIGNATURE OF EUROPAIL SERVICE L	Nav-	_	OSBORN P.O.Bo	ND ADDRESS OF FA IE FUNERA DX # 348	αυν ∖L HOME Williams	port.MD	21795	
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between							t, Approximate interval Between Onset and Death	
NOIL	Sequentially list conditions, fi any, leading to immediate Due to (OR As A CONSEQUENCE OF):								
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	G. DUE TO (OR AS A	CONSEQUENCE OF	7:					
A P	PART II. Other significant condition	ge contribution to death b	ut not resulting i	n the underlyin	g cause given in	Part i. 24s. WAS	AN AUTOPSY FORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
I: MEDIC	Repeter	non				1 _ YE	S 2 NO	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PI	LACE OF DEATH (C	heck only one)			
SIC	1 YES 2 DANG	HOSPITAL: 1 E Inpatient 2 ER/Outp	patient 3 DOA	OTHER: 4 Nursing Horn	ne 5 🗆 Residence	8 Other (Specify)			
H	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME		JURY AT	28d. DESCRIBE HO	W INJURY OCCU	RED	
À	2 Accident Investigation				YES 2 NO				
ETED	3 Suicide 4 Homicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State)							Rural Route Number,	
COMPL	1 1	SICIAN: To the best of my know IER: On the basis of axamination						cause(a) and manner as stated,	
BE	29b. SIGNATURE AND TITLE OF CERTIFIE AMUE	(leav)			29c. LICENSE NU	MBER 55	29d. DATE 5	OGS Heren	
2	30. NAME AND ADDRESS OF PERSON W	TWA PD,	ATH (ITEM 27) (Type,	Print)			7	//	
	31. DATE FILED (Month, Day, Year) MAR 11 1993	32. REGISTRAR'S SIGN							

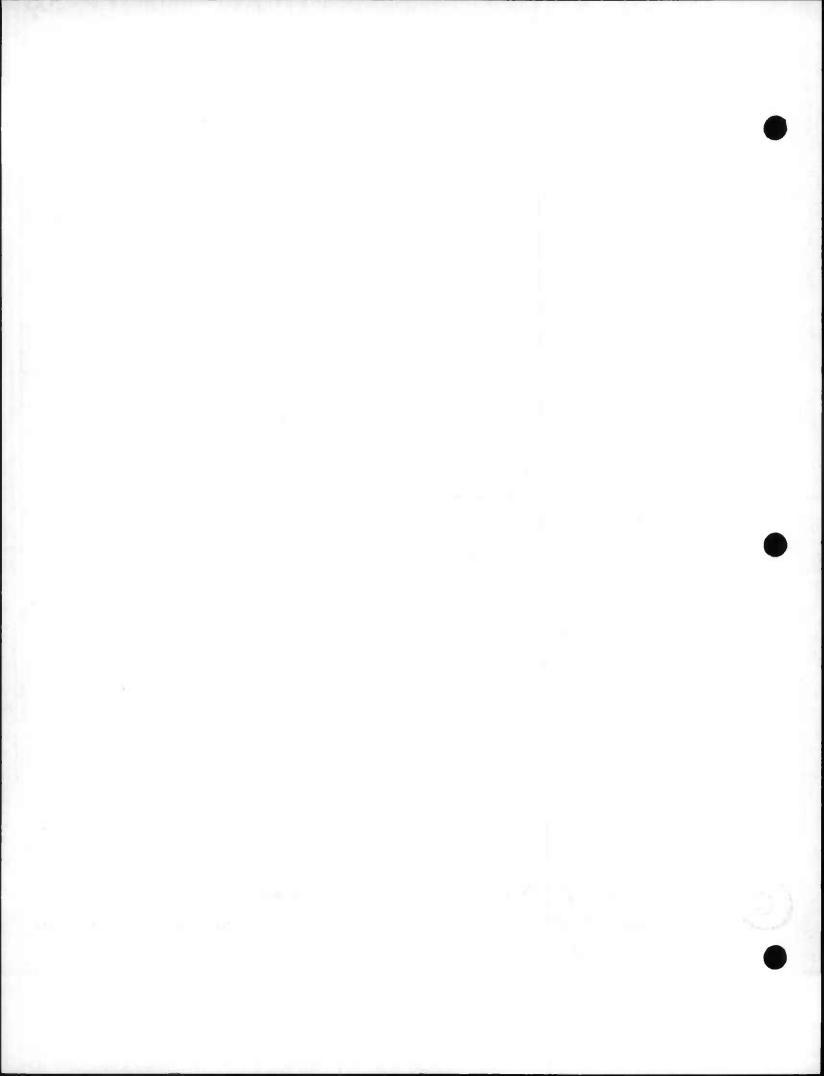


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HYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Deot, of Health and Mental Hydiene prior to burial, cremation, or removal.	The second secon
PITAL OR ATTENDING PHYSICIAN: The law requires that the	INERAL DIRECTOR: After this certificate has been signed by the	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1
HOS H	SE	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 93 08830

	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL HYGIEI		08830	
	1. DECEDENT'S NAME (First, Middle, Lest) Ann	Colquh	noun	JOHNSO	N	2. DATE OF DEATH MONTH March 13		3. TIME OF DEATH 1:35 P M	
1	4. SOCIAL SECURITY NUMBER 216-54-8363 99. FACILITY NAME (If not institution, give a	5. SEX 6. AGE (In yrs. last birthday) 1		MONTHS DAYS	F UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jul. 14, 19	8. (BIRTHPLACE (State or Foreign Country) aryland	
топ	Washington County			Hagerst			USA	OF DEATH	
DIRECTOR	Maryland Prin	r nce: Georges	10c. CI	ry, town or locat Beltsvil				10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
FUNERAL	100. STREET AND NUMBER 11429 Ros	sedale Lane		101	ZIP CODE	705	10g. CITIZEN OF WHAT COUNTRY? USA		
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, spe		NIC ORIGIN? (Specify Years, Puerto Rican, etc.) by:	ns or No 14.	RACE — American Indian, Black, White, etc. Specify: White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of life. Do NOT L	S USUAL OCCUPATIO work done during mo- use retired.)	ON st of working	16b, KIND OF BI	JSINESS/INDUST		
MPL	12		Comput	ter Analy	/st	Govern	ment		
	17. FATHER'S NAME (First, Middle, Last)	V _V 1 ₀	Sco	4.4		AME (First, Middle, Maide		2-1	
BE	Joseph 19a. INFORMANT'S NAME (Type/Print)	Kyle				rion Route Number, City or To		Colquhoun	
임	Gary A.Johnson		1142		ale Lane			*	
	20b. PLAC 1) Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			E AND DATE OF DISPOSITION (Name of DATE 20c. LOCA			ocation — city lerstown	or Town, State	
	21. SIGNATURE OF FUNERAL SERVICE U		-	22. NAME AN	D ADDRESS OF FA				
	23. PART I. Enter the diseases, or shock, or heart failure.	complications that caused List only one cause on as	the death. Do						
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Metada Due To (or As A consi			Sara	oma			Onset and Death	
MOIT	Sequentially list conditions, if any, leading to immediate								
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	CONSEQUENCE OF):							
A	PERFORMED?						24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE		
PHYSICIAN: MEDIC						_	20110	OF DEATH?	
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PL	ACE OF DEATH (C)	eck only one)			
17SI	1 VES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 □ ER/Outpe	etient 3 DDA	4 - Nursing Home		6 Other (Specify)	N. H. W. O. O. O. O. O.		
	1 Netural 5 Pending	(Month, Day, Year)		JURY WO	RK?	28d. DEŞCRIBE HOW	INJURY OCCUR	:0	
TED BY	2 Accident 3 Suicide 8 Could not be determined	Duliging, atc. (Specify)					(Street end Number or Rural Route Number, , State)		
COMPLETED	and a	CIAN: To the best of my knowler: On the basic of examination						ruse(e) and manner se stated.	
BE	296. SIGNATURE AND TITLE OF CERTIFIER Michael 7:	Melamusk			29c. LICENSE NUI		29d. DATE SH	GNED (Month, Day, Year)	
10	30. NAME AND ADDRESS OF PERSON WH	Colmack	ATH (ITEM 27) (Type	o, Print)		,	4.	400 2124	
	31. DATE FILED (Month, Day, Year) MAR 16 1993	32. REGISTRAR'S SIGN		WUWE [1	1-0(,	NEGERA	Nws,	MO. 21740	



The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ding physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should by the prior to burial, cremation, or removal.	d, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed	FTO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and comple be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, ore	IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic e

31. DATE FILSE (MOPING DOX 993

SOURCE CONCENT PROMISE S.EV. S. A. A. S.E. IP TO BE A SOURCE PROMISE S.EV. S. A. A. S.E. IP TO BE A SOURCE PROMISE S.EV. S. A. A. S.E. IP TO BE A SOURCE PROMISE S.EV.		FOR 1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTMI ERTIFICA	ENT OF HEALTH AND TE OF DEATH	MENTAL HYGIEN REG. NO		08831
SOUND SOURCE MARKET MARKET STATE OF STREET STA			Jones			2. DATE OF DEATH MONTH March 12.	AY 1993 YEA	3. TIME OF DEATH
NO COUNTY OF BEATH 1.59 W. Washington Street Washington Washin		219-20-1281	1⊠ M 2 □ F 64	MONT		T DATE OF BURE		RTHPLACE (State or Foreign
STREET AND NAMED TO THE STREET AND MARKET TO BE STREET	TOR		ALCO A CONTRACTOR AND A			DEATH	9c. COUNTY O	
The properties of the proper		Maryland Wash						LIMITS?
The properties of the proper	VERAL	159 W. Washington					10g. CITIZEN O	
Sequentially list conditions, resulting in death) Approximate finance or condition resulting in death) Approximate councer for light sequence on contributing to death but not resulting in the underlying cause given in Part i.		1 Never Married 2 Married	FORCES? 1 K YES 2	RMED NO	If yes, specify Cuban, Mexic	an, Puerto Rican, etc.)	Bi	ack, White, atc.
Sequentially list conditions, tarry list of conditions and per to (Price and Description) Sequentially list conditions, tarry list in diseases, or completeling to death but not resulting in the underlying cause given in Part i. Part II. Other significant conditions of contributing to death but not resulting in the underlying cause given in Part i. Part II. Other significant conditions of contributing to death but not resulting in the underlying cause given in Part i. Part II. Other significant conditions of contributing to death but not resulting in the underlying cause given in Part i. Part II. Other significant conditions of contributing to death but not resulting in the underlying cause given in Part i. Part II. Part III.	APLETED	(Specify only highest grade co	College (1-4 or 5 +)	Sive kind of work do Do NOT use retin	L OCCUPATION one during most of working ad.)		77.77.000000000000000000000000000000000	
Sequentially list conditions Sequentially list list list list list list list list	SE CON	George William J			Franc	es Elizabet	th Davis	
Topographic 2 Sement 2			19	313 N.	ness (Street end Number or Rural Cleveland Ave	Route Number, City or Town	n. State, Zip Code) Stown, M	Maryland
Sequentially list conditions Approximate Complete		1 X Burial 2 Cremetion 3 Remove	al from State 20b. PLACE	AND DATE OF DIS	position(Name of emetery			
22. PARTY. Entar the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) DUE TO (of it is a CONSCOURNCE OF): DUE TO (of it is a CONSCOURNCE OF): DUE TO (of it is a CONSCOURNCE OF): DUE TO (of as a CONSCOURNCE OF): DU		Qualit n.	Minuck		Gerald N. Min Funeral Home	nich 305 Hage	erstown,	
H any, leading to immediate cause enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CO		IMMEDIATE CAUSE (Final disease or condition	et only one cause on each line	Ð.				intarvei Between
PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PROFINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF OEATH (Check only one) 1 VES 2 NO 27. MANNER OF DEATH 1 Noture 1 S Pending Investigation 3 Suicide 6 Could not be determined 28a. DATE OF INJURY At NUMBER 28b. PLACE OF INJURY AT WORK? 1 YES 2 NO 28c. RUJURY AT WORK? 1 YES 2 NO 28c. RUJURY AT WORK? 1 YES 2 NO 28c. PLACE OF INJURY At home, farm, street, factory, office 28c. LOCATION (Street and Number or Flural Route Number, City or Town, State) 29c. CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Vear)	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSE	DUENCE OF):	rehosio.	CY LUKE		
Continue Continue	- 11	PART II. Other algolificant conditions	contributing to death but not r	esulting in tha	underlying cause given in	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
The state of the	SICIAN	EXAMINER?			IER:			
3 Sulcide 4 Homicide 5 Could not be determined 29e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)		1 Netural 5 Pending	(Month, Day, Year)	28b. TIME OF INJURY M	28c, INJURY AT WORK? 1 YES 2 NO		NJURY OCCUREO	
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Year)		4 Homicide determined	zee. PLACE OF INJURY — At ho building, etc. (Specify)	me, farm, street,	factory, office	201. LOCATION (Street e City or Town, State)	nd Number or Rura	l Route Number,
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Year)	OMPL	(Check only						o(e) end menner ee stated.
1 1/0/11/2	BE	296. SIGNATURE AND TITLE OF CERTIFIER	g hapm		_		A	

DEATH (ITEM 27) (Type, Print)

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NG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 m	the state of the beat of the state of the st
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

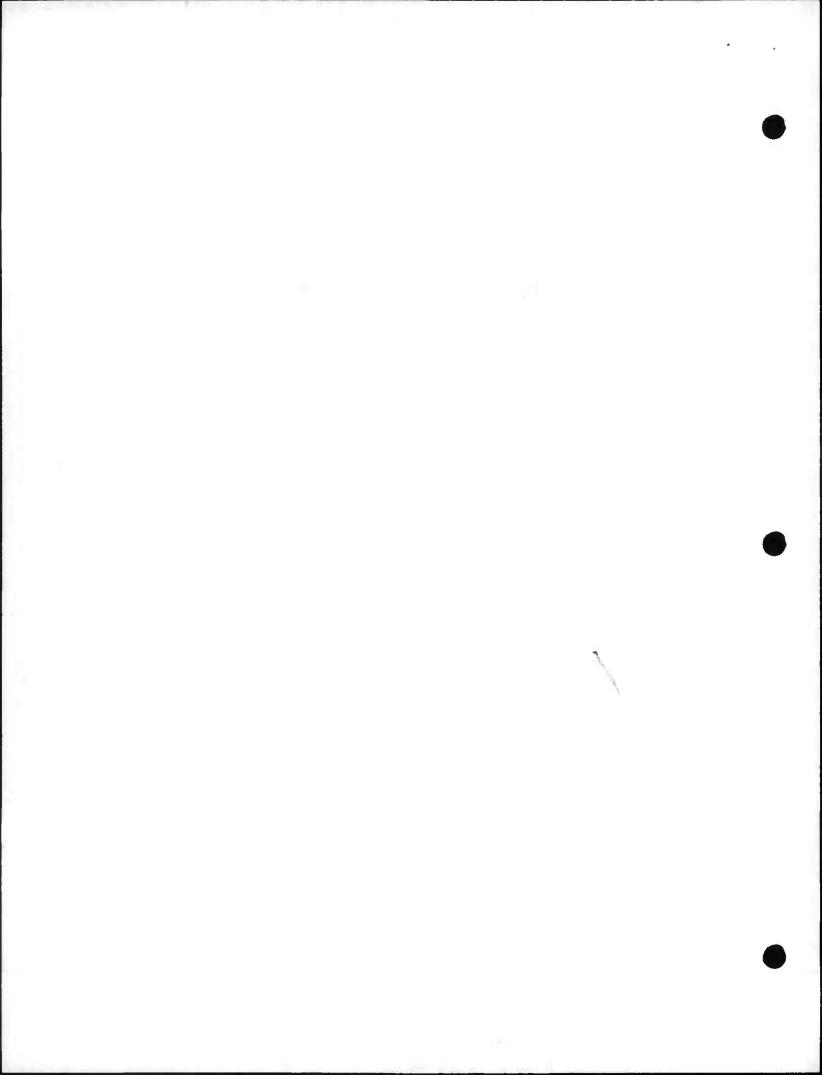
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If New 28 is marked, or New 3 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR		STATE OF I	MARYLAND / DE CER		ENT OF H			ENTAL HYGIEN REG. NO.	E		
1. DECEDENT'S NAME (Firs	t, Middle, Last)						2	DATE OF DEATH	Y	YEAR	3. TIME OF DEATH
RICHARD H		1						3 16		93	2:30A
4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs. lest birt	thday) IF U	INDER 1 YEAR	# UNDER		DATE OF BIRTH (Month, Day, Year)		6. BIRTH Countr	IPLACE (State or Foreign
214-26-112	4	1- M 2 - F	60	YRS.	UAYS.	HOUNS	BRING.	4/24/32		MT	**
9a. FACILITY NAME (If not i		street and number)		9b.	CITY, TOWN	OR LOCATIO	N OF DEAT		9c. COU	NTY OF D	
PP. Nome		v Boin	t VAMC		Deri	in Po	int	MD		Ceci	1
RESIDENCE OF DE	CEDENT					/				0001	
10a. STATE	10b, COUNT	Y			WN OR LOCA						10d. INSIDE CITY LIMITS?
MD	Har	ford		нахх	Aberc	een.	252				1 TYES 2 NO
100. STREET AND NUMBER					10	. ZIP CODE			10g. CIT	IZEN OF V	VHAT COUNTRY?
39 Libe	erty					2100)1			USA	
11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Div	Married				If yes, sp			ORIGIN? (Specify Yes Puerto Rican, etc.)	_	14. RACE	E - American Indian, it, White, etc.
	CEDENT'S EDU ly highest grade				AL OCCUPATION		9	16b. KIND OF BUS	INESS/IN	DUSTRY	

	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIR	тн		E (State or Foreign
- 4	214-26-1124	1-√2 M 2 □ F	60	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Dwy, 1		Country)	
- 3	9a. FACILITY NAME (If not institution, give a	tmet and number)	- 60	_	Sh CITY TOWN	OR LOCATION OF D	4/24/		NTY OF DEATH	
œ					1	^				
2	PP.NAM Perr	y Boint	VAMC		4051	in Point	MD		Cecil	
입	10a, STATE 10b, COUNTY			10c CIT	Y, TOWN OR LOCA	TION			1404	MANUAL OUTM
DIRECTOR	}								100.	INSIDE CITY LIMITS?
		ford		Ma	Aber	STREE			15	YES 2 NO
₹	10s. STREET AND NUMBER				10	H. ZIP CODE		10g. CIT	IZEN OF WHAT	COUNTRY?
FUNERAL	39 Liberty					21001			USA	
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AR	MED	13. WAS DE	CENDENT OF HISPA	NIC ORIGIN? (Spec			nerican Indian, e, etc.
	1 Never Married 2 Married	IF YES, GIVE WI	YYES 2 N	#D		pecify Cuben, Mexico S 2 X NO Specif		HC.)	Black, White Specify:	e, etc.
B	3 🗍 Widowed 4 🗍 Divorced	1950	1953			o I (Ano specia	y.		В	lack
COMPLETED	15. DECEDENT'S EDUC	CATION			USUAL OCCUPAT		16b, KIND	OF BUSINESS/INC		
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	- Ilda	ive kind of a Do NOT us	work done during me se retired.)	ost of working				
4	12	50110g0 (1-9 01 5 Y)		Tabe	orer		1 100	771 77	T = 10 == == =	
S	17. FATHER'S NAME (First, Middle, Last)			парс	orer	to MOTUEDIO N	LME (First, Middle, I	cal gov	vermme	пс
	The second second									
BE	Stewart G	arland					<u>ine Jer</u>			
2	Contour Day State Cox		191	b. MAILING	ADDRESS (Street	and Number or Rural	Route Number, City	or Town, Statu, Zic	Code)	
	Lois Jordan			39	Liber	y St.	Aberde	een, MI		
,	20a. METHOD OF DISPOSITION 1 № Burial 2 □ Cremation 3 □ Remo	nual from State			OF DISPOSITION (A	ame of	DATE 2	0c. LOCATION -	City or Town, St	ate
2	4 Donation 5 Other (Specify)	ovai irom suite	cemetery, cre St.	Jar	nes Cer	n	3-20	Havre	de Gr	ace, MD
	21. SIGNATURE OF FUNERAL SERVICE LIG	ZNSEE /	1		22. NAME A	ND ADDRESS OF FA	CILITY			
		/ //				old Bear				
	Makes 11.	Lolling	1		P.O.	Box 18	88 Havi	ce de (Grace,	M21078
	23. PART I. Enter the diseases, or o shock, or heart failure.	omplications that	caused the de	ath. Do r	not enter the m	ode of dying, suc	h as cardiac or	respiratory an	rest,	Approximate
	IMMEDIATE CAUSE (Final	or so, carrier							i'	Interval Between Onset and Death
	disease or condition	(0)	MA /	Lon	11				i	3.1.
- 1	resulting in death)	e. DUE TO	OR AS A CONSEC	DUENCE O	FI:) wors
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ō l	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSEC	DUENCE OF	n:	THE THE	105			
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₹ I	cause. Enter UNDERLYING	Page	not 11		1.	11	V KOL-			
FICAT	cause. Enter UNDERLYING CAUSE (Disease or injury that intrinsical execute	e Recu	DR AS A CONSEC	DUENCE OF	Fin //1	not du	fatruns			
TIFICAT	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (DR AS A CONSEC	QUENCE O	F):	not ch	ferhuns			
CERTIFICAT		DUE TO	DR AS A CONSEC	QUENCE OF	Fi:	not du	fedruns			
L CERTIFICATION	resulting in death) LAST	d						WAS AN AUTOPSY	24b. WERE	AUTOPSY FINDINGS
	PART II. Other significent condition	s contributing to	death but not n	esuiting	in the Underlyir	ng cause given in	Part I. 24a. V		AMIL	ABLE PRIOR TO
	PART II. Other significent condition	s contributing to	death but not n	esuiting	in the Underlyir		Part I. 24a. V	WAS AN AUTOPSY	AMIL	ABLE PRIOR TO LETION OF CAUSE
MEDICAL	resulting in death) LAST	s contributing to	death but not n	esuiting	in the Underlyir	ng cause given in	Part I. 24a. V	WAS AN AUTOPSY ERFORMED?	MAIL. COMP OF DE	ABLE PRIOR TO LETION OF CAUSE
MEDICAL	PART II. Other significent condition Hyperters on Director M	s contributing to	death but not n	esuiting	in the Underlyir	ng cause given in	Part I. 24a. V	WAS AN AUTOPSY ERFORMED?	MAIL. COMP OF DE	ABLE PRIOR TO LETION OF CAUSE EATH?
AN: MEDICAL	PART II. Other significent condition Hyperters on Diright M 25. WAS CASE REFERRED TO MEDICAL	s contributing to a	death but not n	esuiting	in the underlying	ng cause given in	Part I. 24a. W	WAS AN AUTOPSY ERFORMED?	MAIL. COMP OF DE	ABLE PRIOR TO LETION OF CAUSE EATH?
AN: MEDICAL	PART II. Other significent condition Hyperters on Director M	s contributing to	death but not r	esulting	in the underlyin	ig cause given in	Part I. 24a. W P 1 1 1 1	WAS AN AUTOPSY ERFORMED? YES 2 NO	MAIL. COMP OF DE	ABLE PRIOR TO LETION OF CAUSE EATH?
AN: MEDICAL	PART II. Other significent condition Hyperters on Director on 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	s contributing to d	death but not n	□ DOA 28b. TIM	26. F OTHER: 4 Nursing Hot	LACE OF DEATH (Change 5 Residence	Part I. 24e. W P 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	WAS AN AUTOPSY ERFORMED? YES 2 NO	AMAIL COMPOSE OF DE	ABLE PRIOR TO LETION OF CAUSE EATH?
PHYSICIAN: MEDICAL	PART II. Other significent condition Hypertere con Director con Director con 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	s contributing to o	death but not n	□ DOA 28b. TIM	28. F OTHER: 4 Nursing Hotel E OF 28c. IN WRY W	LACE OF DEATH (CA	Part I. 24e. W P 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	WAS AN AUTOPSY PERFORMED? YES 2 NO	AMAIL COMPOSE OF DE	ABLE PRIOR TO LETION OF CAUSE EATH?
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Julia Davidson-Randalle MAR 1 9 '93



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

INVISION OF VITAL DECCING, F.C. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attenting physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the huneral director, page 5 should be detached for use as the bunda-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunda, cremation, or removal.

IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

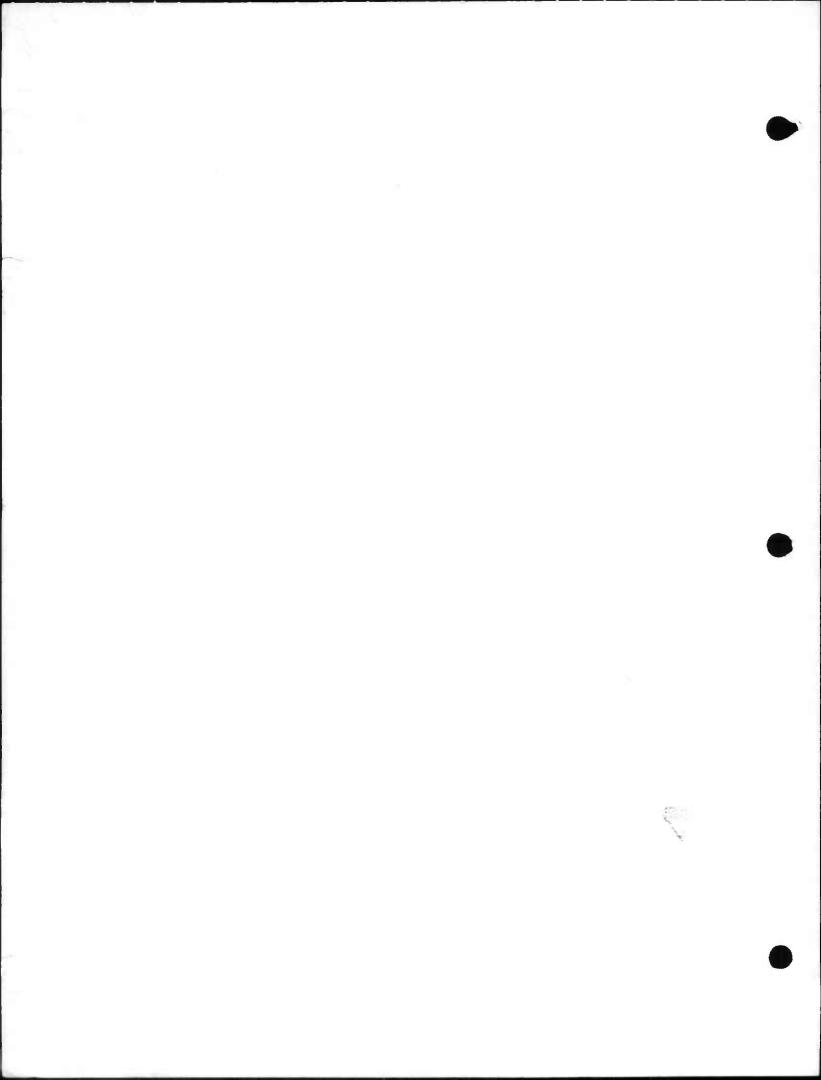
	REGISTRAR		CERTIFIC	ATE OF DEATH	REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)		11115011		2. DATE OF DEATH MONTH D	AY YEAR	3. TIME OF DEATH
- 6	4. SOCIAL SECURITY NUMBER	1 1 1 1 1 1	HWSOW E (In yrs. last birthday)	F UNDER 1 YEAR IF UNDER 24 HRS.	March 13	2//	10:10A. M
1	214-12-7504	1 🔀 M 2 🗆 F		F UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH 1-14-1907	8. SIRTI Count H.	HPLACE (State or Foreign hy). 111top, MD
"	9a. FACILITY NAME (If not institution, give			b. CITY, TOWN OR LOCATION OF D	DEATH	9c. COUNTY OF D	
CTO	Physicians Memor		1	LaPlata		Char	les
DIRE		harles	10c. crty, 1 Pon	TOWN OR LOCATION			10d. INSIDE CITY LIMITS? 1 ☐ YES 243 NO
VERAL	Rt. 2 Box 153			10f. ZIP CODE 206	75	USA	WHAT COUNTRY?
BY FUNERAL DIRECTOR	11. MARITAL STATUS 1 Never Married ZZZZMarried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR		13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 — YES 2 NO Specify	an, Puerto Rican, atc.)	s or No— 14. RAC Blac Spec	E — American Indian, k, Whita, atc. :://y: White
	15. DECEDENT'S EDU (Specify only highest grade	ICATION completed)	18a. DECEDENT'S US	UAL OCCUPATION	16b. KIND OF BU	SINESS/INDUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Gas Att	a done during most of working of most of working of most of working endant	US Go	vernment	
BE CON	17. FATHER'S NAME (First, Middle, Last) Cornelius Johnson	n		18. MOTHER'S N.	AME (First, Middle, Malden izabeth Si	Surname)	
TO B	19a. INFORMANT'S NAME (Type/Print) Mabel Johnson		196. MAILING AC Rt. 2 B	or 153, Pomfre	Route Number, City or Tow t, Md. 206	n, State, Zip Code)	
	20a. METHOD OF DISPOSITION 1 X Burlat 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	noval from State 26	0b. PLACEAND DATE OF I	DISPOSITION (Name of place) Morial Gardens	DATE 20c. LO	CATION — City or To	own, Stata
	21. SIGNATURE OF FUNERAL SERVICE L	Mark G. Br	ohawn M000	32. NAME AND ADDRESS OF FUNTT Funer	ICILITY	dorr, Ma.	•
	19an /4/	Dution		P. O. Box 1	56, Waldor	f, Md.	
	IMMEDIATE CAUSE (Finsi	List only one cause on	aach line.		ch as cardiac or reap	ratory arreat,	Approximata interval Between Onset and Death
_					The		
EDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE OF):	LYDHYOPA KDIAL INF	10000	`	
LIFIC	that initiated events	C. DUE TO (OR AS	A CONSEQUENCE OF):	אכטואכ (גון-	ARCCI (OX	J	
CERT	resulting in death) LAST	d					
CAL	PART ii. Other aignificant condition	na contributing to death	but not resulting in t	he underlying cause given in	Part i. 24s. WAS AN PERFOR		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
MEDI					1 [] YES 2	NO NO	OF DEATH?
ä							1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	Ι σ	28. PLACE OF DEATH (C)	neck only one)		
14S	1 VES 2 NO	1 Inpatient 2 FR/Out 28a. DATE OF INJURY	tpetlant 3 DOA 4	☐ Nursing Home 5 ☐ Rasidenca			
BY PI	1 Netural 5 Pending	(Month, Day, Year)		F 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DEŞCRIBE HOW II	NJURY OCCURED	
	2 Accident Investigation 3 Suicide 8 Could not be determined	28a. PLACE OF INJUR building, atc. (Spi	IY — At home, larm, atre-	et, factory, office	281. LOCATION (Street a City or Town, State)	and Number or Rural F	Route Number,
COMPLET				t the time, data and placa, and dus			
			on and/or investigation, is	n my opinion, death occured at the	tima, data and placa, an	d dua to the cause(s) and manner as stated.
H	29b. SIGNATURE AND TITLE OF CERTIFIER	14 9		29c. LICENSE NU		29d. DATE SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF D	EATH (ITEM 27) (Type, Pri	1 10161	32	- 3//=	2/7.5
	Nallan Ramakrishn				ter Waldor	f Md 2060	12
F	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	NATURE Rando 12		THO THUT	2000	14-

	r
BOX 68760,	
P.O.	
RECORDS, P	
F VITAL	
DIVISION	

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOPPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

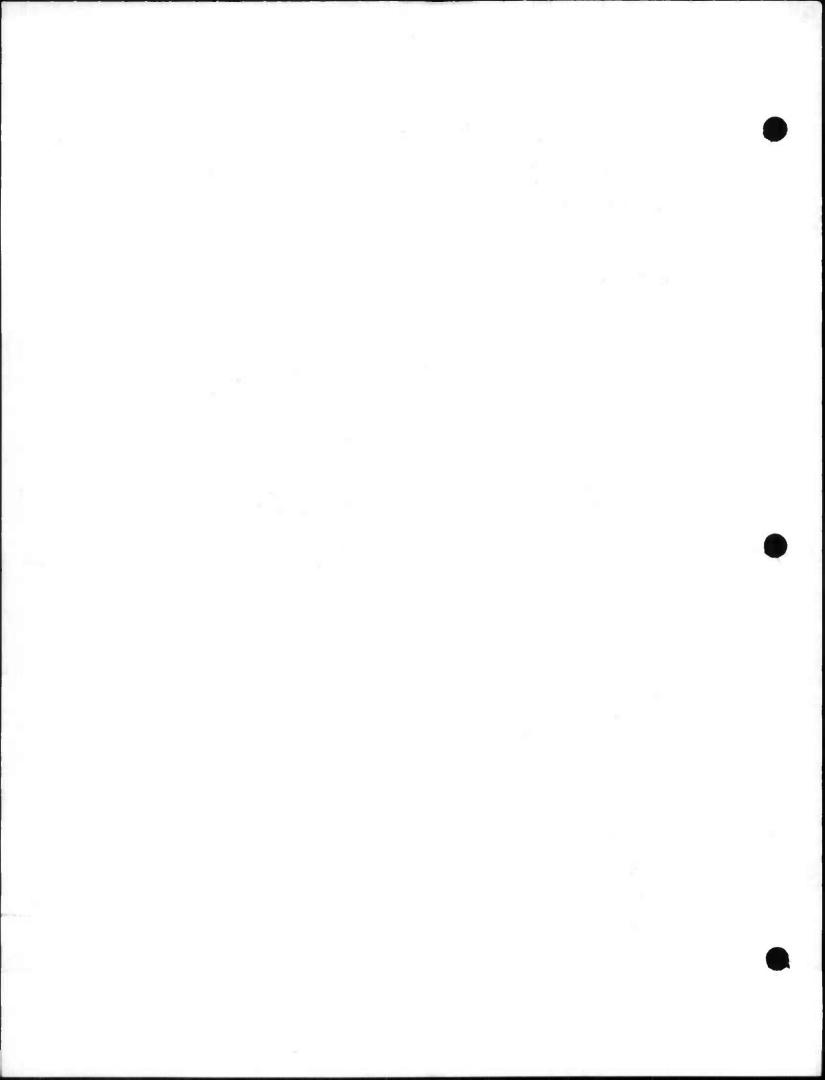
	1 - FOR STATE REGISTRAR	STATE OF MAI	RYLAND /	DEPARTM	ENT OF H	EALTH AND	MENTA	L HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)							OF DEATH		3. TIME OF DEATH
	NATHANIEL BELL	KERR					MAR		1993	6:15 P M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. las		UNDER 1 YEAR	IF UNDER 24 HRS	7. DATE	OF BIRTH	8.	BIRTHPLACE (State or Foreign
	270100310	1 X M 2 □ F	88	YRS.	NTHS DAYS	HOURS MIN		.15,190		Country) IRGINIA
	9s. FACILITY NAME (If not institution, give stre	net and number)		96	CITY, TOWN	R LOCATION OF		1,7	9c. COUNTY	OF OEATH
6	RANDOLPH HILLS N	NURSING CE	ENTER		WHEA	TON			MOI	NTGOMERY
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			10c. CITY. TI	OWN OR LOCAT	IOM				10d. INSIDE CITY
DIR.	MARYLAND MON	NTGOMERY			ER SPF					LIMITS?
	10e. STREET AND NUMBER	TOOTEKI		DIE.		ZIP CODE			10a, CITIZEI	N OF WHAT COUNTRY?
FUNERAL	3704 FAIRLY STREET	Γ			_	2090	5		US	
5	11. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. AR	MEO	13. WAS DEC	ENDENT OF HIS	ANIC ORIGI	N? (Specify Yes		. RACE — American Indian.
BYF	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 X		10		2 NO Spe		Rican, atc.)		Black, White, etc. Specify:
	200				<u> </u>					WHITE
	15. DECEDENT'S EDUCA (Specify only highest grade of	ompleted)	(G	CEDENT'S USU We kind of work Do NOT use re	done during mo	N st of working	160	b. KIND OF BUS	SINESS/INDUS	TRY
٦	Elementary/Secondary (0-12) Q	College (1-4 or 5+)	100		,	TRANSI	,			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		פטען	DKIVE	. Б.С.	16. MOTHER'S		Adiddle Adeides	Comment	
	CHARLES H. KERF	₹						BORDEN		
BE	19s. INFORMANT'S NAME (Type/Print)		191	. MAILING AD	ORESS (Street a	nd Number or Rui				del
의	MARGARET K. HITTE	(DAUGHT			AIRLY S					RYLAND 20906
	20e. METHOD OF DISPOSITION	mi from State	20b. PLACE	NDDATEOFD	SPOSITION (Na		OAT			or Town, State
	4 Donation 5 Other (Specify)	27 702 300		TEW CI	ece) EMETERY		3/	12 WAYN	NESBOR	O, VIRGINIA
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE				D ADDRESS OF	FACILITY			
	liganth	vol. Car	mode.	11						ME, INC. PR.,MD.20901
	23. PART I. Enter the diseases, or co	pplications that ca	used the de	ath. Do not	entar the mo	de of dying, s	ch as cer	diac or reapi	ratory screet	Approximate
	shock, or heart fellure. Li IMMEDIATE CAUSE (Final	st only ona cause	on aach Ilna							Interval Between Onset and Death
	disesse or condition resulting in death)	Meum	AS A CONSEC							2 weeks
		OUE TO (OR	AS A CONSEC	UENCE OF):					_	1700 0- 100
S S	Sequentially list conditions, b.		ila ilaina							
CERTIFICATION	if sny, landing to immediata cause. Enter UNDERLYING	DOF 10 (OH	AS A CONSEC	UENCE OF):						
임	CAUSE (Disease or Injury that initiated events	DUE TO (OR	AS A CONSEC	UENCE OF):						
ᇎ	resulting in death) LAST									į
뜅┃	d.									
¥	PART II. Other significent conditiona	contributing to dea	ith but not r	esuiting in th	na underlying	ceuse given	n Part i.	24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
PHYSICIAN: MEDIC	auguemens.	cemenus	2					1 - YES 2	NO	COMPLETION OF CAUSE OF DEATH?
Σ										1 TYES 2 NO
¥	25. WAS CASE REFERRED TO MEDICAL									
딣┃	EXAMINER?	HOSPITAL:		01	HER:	ACE OF OEATH (
Ĕ∥	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	I Inpatient 2 ER		28b. TIME OF		5 Residence	_	SCRIBE HOW II	FILIBA OCCUB	50
	27. MANNER OF DEATH	28s. OATE OF INJU				RK?		OTHER HOTE		20
	1 Natural 5 Pending	28a. OATE OF INJL (Month, Day, Ye		INJURY			1			
β	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye	JURY At hor		M 1 🗆 Y	ES 2 NO	26f. LOC	ATION (Street a	nd Number or I	Rural Floute Number,
β	1 Natural 5 Pending Investigation	(Month, Day, Ye	JURY At hor		M 1 🗆 Y		26f. LOC City	CATION (Street e or Town, State)	ind Number or I	Rural Route Number,
ETED BY	Netural 5 Pending Investigation 3 Suicide 6 Could not be determined	(Month, Day, Ye 28e. PLACE OF IN- building, atc.	JURY At hor (Specify)	ne, ferm, stree	M 1 TY	ES 2 NO	City	or Town, State)		Rural Route Number,
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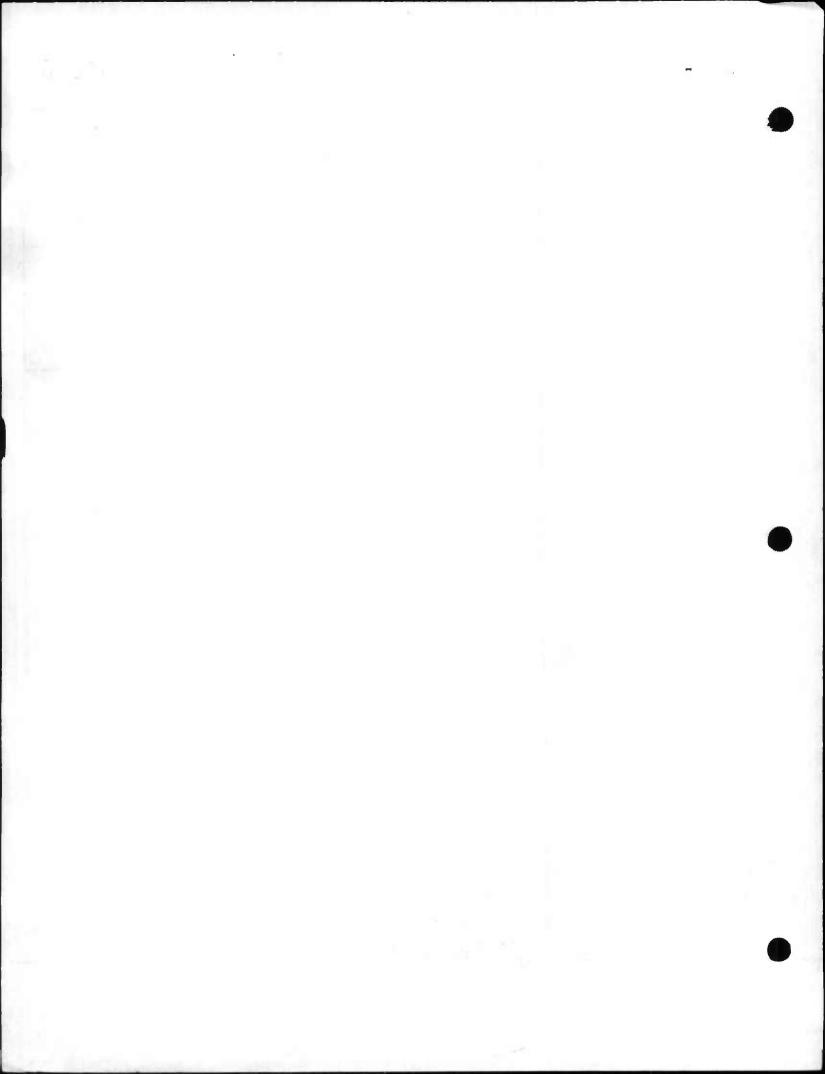
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	1 - STATE REGISTRAR		STATE OF I	MARYLAND C	DEPAR	RTMENT ICATE	OF HEAL	TH AND	MENTAL HYGIEI REG. NO			
	1. DECEDENT'S NAME (First	, Middle, Last)	Melvy	Ivyn Kro	Kra F	ft			2. DATE OF DEATH MONTH 3	MY 11	93	3. TIME OF DEATH
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. In	st birthday)	IF UNDER 1	YEAR IF U	NOER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		9. BIRTHPI Country)	LACE (State or Foreign
	579-05-40		1 M 2 🗆 F	8,	YRS.				7-16-1		Was	sh., D.C.
<u>~</u>	Se. FACILITY NAME (If not in							CATION OF D	EATH	9c. COI	UNTY OF DEA	ATN
18	Suburban H	lospita CEDENT	al			Be	thesda	1		M	ontgor	nery
DIRECTOR	10a, STATE	10b. COUNT	Y			Y, TOWN OF		D. C			-1	IOd. INSIDE CITY
					W	asnin	gton,				1	X LIMITS?
FUNERAL	10e. STREET AND NUMBER						10f, ZIP			10g. CI		AT COUNTRY?
NE I	4000 Massa	chuset	12 WAS DECEDEN	T EVED IN U.C. A	RMED	13 W	AS DECEMBE	2001	NIC ORIGIN? (Specify Ve	n or Mo	USA	A
	1 Never Married 2		FORCES? 1	YES 2 V	NO	16	yes, specify (en, Puerto Rican, etc.)	# OF 140-	Black, Specify:	- American Indian, White, atc.
ЭВУ	3 Widowed 4 Divo							THE CHECK			V	White
COMPLETED	(Specify only	EDENT'S EOU y highest grade	completed)	(0	ECEDENT'S Sive kind of a. Do NOT u	USUAL OCC	CUPATION iring most of w	vorking	16b. KIND OF BU	SINESS/IN	DUSTRY	
1 2	Elementary/Secondary (0)-12)	College (1-4 or 5	+)			. D	. 1	0-16	7		
OM	17. FATHER'S NAME (First, M		,		ear	estate		loper	Self-			
BE C	William B	. Krai	t						Scheer	,		
0	19a. INFORMANT'S NAME (7	ype/Print)		19	b. MAILING	ADDRESS	Street and Nu	mber or Rural	Route Number, City or Tox	rn, State, Zi	ip Code)	
	Helen Kr								ashington,			
	26s. METHOD OF DISPOSITI		oval from State	cametery, cri	emetory or o	ther place)	ION (Name of		OATE 20c. L			
	4 Donation 5 Other 21. SIGNATURE OF FUNERA		CENSEE	- IWash.	Hebre	EW COI	ng. Me	m. Pa	rk 3/14 W	ashi	ngton,	D.C.
1	Mic	how	18-M	als.	~	Jo	seph	Gawle	r's Sons, in Ave,NW,		ingtor	DC 20016
	23. PART i. Enter the di	iseasea, or o	complications that List only one ceu	t caused the d	eath. Do	not enter t	ha moda pi	dying, aud	ch as cardiac Dr resp	iretory a	rreat,	Approximate
	IMMEDIATE CAUSE (Findisease or condition		0				R	1	0			Interval Between Onset and Death
	resulting in death)	→	a. /	OR AS A CONSE	me	1 +1	Ley	Fai	luz			4wells-
,				(ON AS A CONSE	OUENCE U	r):						
[일	Sequentially list conditi if any, leading to imme-		OUE TO	(OR AS A CONSE	OUENCE O	F):						
S	cause. Enter UNDERLYi CAUSE (Disease or Inju		c									
ERTIFICATION	thet initiated events resulting in death) LAS	T	DUE TO	(OR AS A CONSE	OUENCE O	F):						
S			d									<u> </u>
SAL	PART II. Other aignifica	C. V	s contributing to	death but not	reauiting	in the und	erlying cau	se given in	Part I. 24a. WAS AI PERFO		A	VERE AUTOPSY FINDINGS
MEDICA	B	an							1 YES	NO		OMPLETION OF CAUSE OF DEATN?
	Po	1 a	C 2.	y-Varent	1				—		1	YES 2 NO
IAN	25. WAS CASE REFERRED TO	O MEDICAL	Corer	e varest	a		26. PLACE C	OF DEATH (C)	eck only one)			
SIC	1 YES 2 NO		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:		Residence	8 Other (Specify)			
BY PHYSICIAN		Pending Investigation	28a. DATE OF (Month, D		28b. TIN		8c. INJURY A WORK? 1 YES	T	28d. DESCRIBE NOW	NJURY OC	CURED	
유	3 Suicide 6	Could not be determined	28e. PLACE O building,	F INJURY — At he etc. (Specify)	ome, term,	street, tector	y, offica		28t. LOCATION (Street City or Town, State	and Numbe	er or Rural Rou	ite Number,
J.E.	29a. CERTIFIER CERT	IFYING PHYSI	CIAN: To the best of	my knowledge, de	ath occur	ed at the tim	e, data and n	lace and due	to the cause(a) and ma	oper se etc	ted	
COMPLET									time, data and place, a			and manner as stated.
BE C	296. SIGNATURE AND TITLE	7		_			29c.	LICENSE NU	MBER	294 DAT		fonth, Day, Year)
TO B	m	1	12h				1	205	76	•	3/11/	9 }
	30. NAME ADORESS OF	PERSON WH	1 Ca	erseto	mh	Ro) /	Beth.	76 w/1 /2	rid	201	714
	31. DATE FILED (Month, Day, MAR 16		32. REGISTRA	R'S SIGNATURE	Banda Pi	2						
	MAIL TO	'9 3	June	- TO LANDON	1							OHMH-16 Bay 1/89



NSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. It is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.

	1 - FOR STATE REGISTRAR	STATE OF MA			MENT OF H		MENTAL HYGIEN	E	00000	
	1. DECEDENT'S NAME (First, Middle, Last) MAREK	K	APL	AN			2. DATE OF DEATH DO	- 9"	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 109-36-2537	1 X M 2 D F	YRS.	IF UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 9-1-1911	8.	BIRTHPLACE (State or Foreign Country) Poland		
TOR	9a. FACILITY NAME (If not institution, give Holy Cross Hospi RESIDENCE OF DECEDENT					Spring	EATH	Mont	gomery	
DIRECTOR	Maryland Monte		town or Locat			10d. INSIDE CITY LIMITS?				
FUNERAL	100. STREET AND NUMBER 1316 Fenwick I	ane			101.	20904		U.S.	OF WHAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 IT IF YES, GIVE WAR	YES 2 N	MED	If yes, spe	ENDENT OF HISPA city Cuben, Mexic 2 A NO Speci	NIC ORIGIN? (Specify Yes en, Puerto Rican, etc.) fy:		RACE — American Indian, Black, White, stc. Specify: White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Gir lifte.	ve kind of wor Do NOT use i		N It of working	16b. KIND OF BUS			
₩ 0	17. FATHER'S NAME (First, Middle, Last)	5 +	P	hysic	1an	18 MOTHED'S N	Medic Me			
BE C	Samuel Kaplan					Chasia		,		
5	19a. INFORMANT'S NAME (Type/Print) Gilbert B. Kapl	an					Aoute Number, City or Town		de)	
	20a, METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Rem		20b. PLACE A	NDDATEOF	DISPOSITION (Nat		OATE 20c. LO	CATION — City	or Town, State	
	4 Donetion 5 Dother (Specify) 21. SIGNATURE OF FUNERAL SETURE LI	CENSEE 7	remetery, crer Temp	le Is	22. NAME AN	D ADDRESS OF FA				
	· 4	5.16	-	_			Funeral Ho shire Ave.		20904 Spring, M.D.	
	23. PART I. Enter the diseasea, or complications that caused the deeth. Do not enter the mode of dying, such ea cardiec or reapiratory arrest, shock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition a. As produced to produced the produced to produced the produced to produced the produced to produced the produced to produced the produced to produced the produced to produced to produce the produced to produce the									
ATION	Sequentially list conditions, Due to lor as a consequence on								10 days	
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in desth) LAST	or injury onts DUE TO (OR AS A CONSEQUENCE OF):								
AL C	PART II. Other algnificant condition	na contributing to de						AUTOPSY	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO	
PHYSICIAN: MEDIC	diakele	meilibo d					1 YES 2	4	OF DEATH?	
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			26. PL	ACE OF DEATH (C)				
	1 YES 2 10 10 27. MANNER OF DEATH 1 Natural 5 Pending	1 Unpatient 2 EF 28e. DATE OF INJ (Month, Day.)	URY	28b. TIME O	OF 28c. INJU	RY AT	5 Other (Specify) 28d. DESCRIBE HOW II	JURY OCCUR	ED	
ED BY	1 Matural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined determined 4 Homicide 1 Ho							Rural Route Number,		
COMPLETED							to the cause(e) and man		Duse(s) and menner se stated.	
BE	296. SIGNATURE AND TITLE OF CERTIFIE	fleley				29c. LICENSE NUI		29d. DATE SI	GNEO (Month, Day, Year)	
5	30. NAME AND ADDRESS OF PERSON WH Deborah Goldberg				·			20814		
	31. DATE FILED (Month, Day, Year) MAR 17 '03	32. REGISTRAR'S								
الـــــــــــــــــــــــــــــــــــــ		TO TO TORO	CACO CO	To Bridge						



BALTIMORE, MARYLAND	ours after death. Page 6 may be retained by the hos	in by the funeral director, page 5 should be detache or removal.	nedical examiner must be notified at once.
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DIVISION OF VITAL RECORDS, P.O. BOX 13146,	TO THE HOSPITURE ASSESSMENT THE BASE Equipment of the properties of the hospiture of the ho	TO THE FUNERAL WHENCE AND THE CENTRALE has been signed by the attending physician and completely mind in by the funeral director, page 5 should be detached the filed within 72 has a min come with the State Deet, of Health and Mental Hyglene prior to burkal, cremation, or removal.	IMPORTANT. If them zers marked, or them 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISIO	TO THE HOSPITALION SPECIAL	TO THE FUNERAL WIFE BERN	IMPORTANT II IIIII 20 II

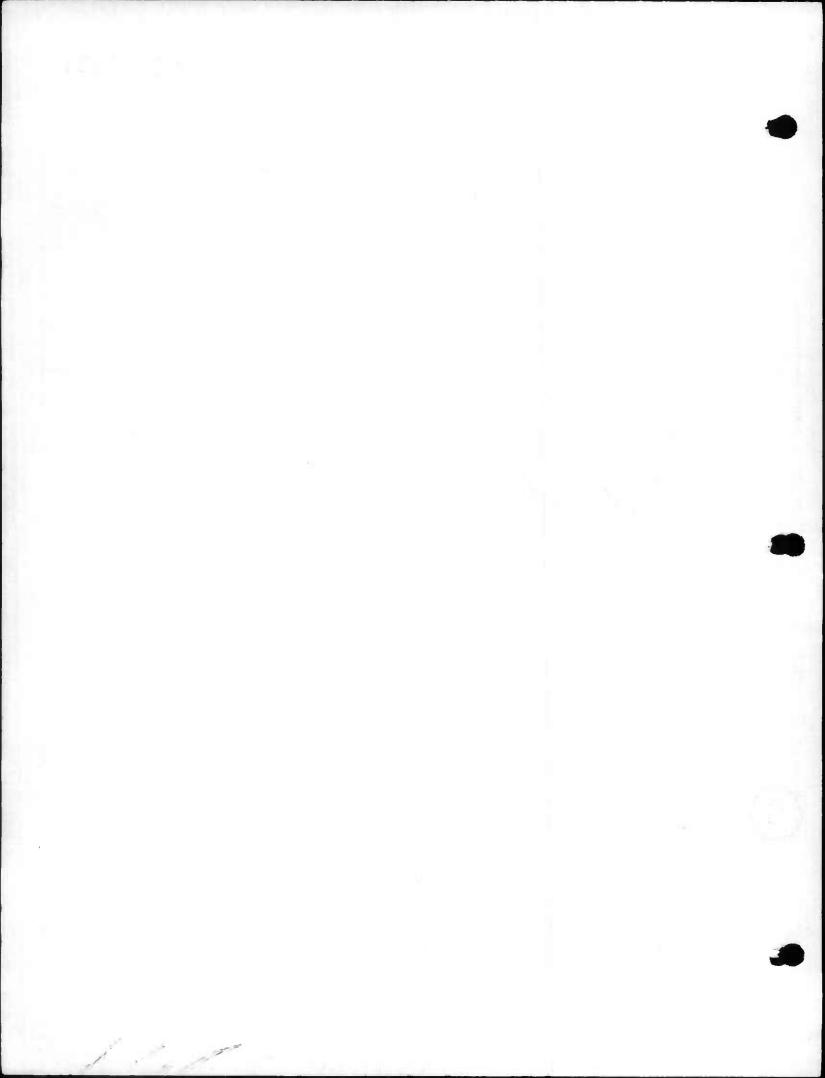
31. DATE FILED (Mon

'93

32. REGISTRAR'S SIGNATURE

							93	08837	
	FOR 1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIE REG. N			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY / C) YE	3. TIME OF DEATH	0
	Ostap Kotyk-Step	anovych				03	10 9	B 4 +	M
	4. SOCIAL SECURITY NUMBER		in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Yogir)	8.	BIRTNPLACE (State or Foreig	n
	127-24-6718	1 M 2 □ F	45 YRS.	MONTHS DATS	HOUNS MIN.	2/10/9	20	kraine	
	9a. FACILITY NAME (If not institution, give st	meet and number);	1 0:	96. CITY, TOWN O	R LOCATION OF D	EATN	9c. COUNTY	OF DEATN	
DIRECTOR	Springhrook	duential/	S9 Ctr.	Silve	וקכחי	ina	IMC	nt gomer	7
L C	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c CIT	Y, TOWN OR LOCAT	ION			100, INSIDE CITY	7
Ä	md Ma	20000	1 6	11/10-	So cir	10		LIMITS?	
	10e, STREET AND NUMBER	Hyomer	4 1 -2	I WCI -	ZIPCODE	19	10a CITIZEN	1 YES 2 NO	
FUNERAL	12375 Alous	1 Homes	hirp	AND	200	244			
NE	11. MARITAL STATUS	12. WAS DECEDENTIEVER IN	THE APPLE	40 1110 050	<u>~U</u>	NIC ORIGIN? (Specify Y		S.A. RACE — American Indian,	_
	1 Never Merried 2 Merried	FORCES? 1 YES	2 V NO	If yes, spe	cify Cuban, Mexico	an, Puerlo Rican, etc.)	88 OF NO 14.	Black, White, atc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES	1 🗆 YES	2 NO Specif	fy:		Specify: White	
ED	15. DECEDENT'S EDUC	CATION	16a. DECEDENT'S	USUAL OCCUPATIO	N .	16b. KIND OF B	USINESS/INDUST	RY	_
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of v	vork done during mos se retired.)	st of working	100, 52, 74			
4	12	+5	Econ	omist		Fina	ncial		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Malde			
	Stephan Kotyk-	Stepanovych			Katery	vna Loush	am		
BE (19e. INFORMANT'S NAME (Type/Print)			ADDRESS (Street e		Floute Number, City or To		de)	
5	Tatiana Yasinsky		925	Schind1	er Drive	e Silver S	pring.M	L.D. 20903	
- 1	20e. METNOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or 20c. LOCATION — City or Town. Stata								
	1 Cremetion 3 General from State St. Andrews Ukranian Cemetery South Bound Brook, N.J.								
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE /			D ADDRESS OF FA				
	► X W.L. 1/ K	110/10				Funeral H		20904.	
	23. PART I. Enter the diseases, or o	eries in the same	d Abo dooth Doo	111800	NewHamps	shire Ave.	Silvers	pring, M.D.	_
	shock, or heart failure.	List only one cause on e	ach ilna.	ot antar tha mo	ua or dying, suc	on se cardiac or rea	piratory arrest	Interval Bath	vean
	iMMEDIATE CAUSE (Final disease or condition		(D)	1//0-	I Far	0.		Onset and D	eath
	reaulting in death)		p Copu		1 par	cey		regis	
		DUE TO (OR AS A	CONSEQUENCE O	F):					
O	Sequentially list conditions,	DUE TO (OR AS (CONSEQUENCE OF	D.					
ATI	if any, leading to immadiata cause. Entar UNDERLYING	50E 10 (011 A5 A	CONSCOURTE OF	,.					
FIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS /	CONSEQUENCE OF	F):				<u> </u>	
CERTIFICATION	resulting in death) LAST		Control of the Contro	,					
CE		1							
	PART II. Other significant condition	a contributing to death b	out not resulting	in tha underlying	cause given in		N AUTOPSY ORMED?	24b. WERE AUTOPSY FINDS AVAILABLE PRIOR TO	INGS
MEDICAL						1 D YES		COMPLETION OF CAUS DF DEATH?	SE
MEC								1 NES 2 NO	
ä									
M	25. WAS CASE REFERRED TO MEDICAL			26, PL	ACE OF DEATH (C	heck only one)			
Sic	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outp	patient 3 DOA	4 Thursing Nom	e 5 🗆 Residence	8 Other (Specify)			
PHYSICIAN:	27. MANNER OF OEATH	28e. DATE OF INJURY	28b. TIM			28d. DESCRIBE NOV	INJURY OCCUR	ED	
ВУР	1 Nitiural 5 Pending	(Month, Day, Year)	1140		RK7 /ES 2 NO				
	2 Accident Investigation 3 Suicide 6 Could not be	28a, PLACE OF INJURY	At home, ferm,	street, factory, office	•	281, LOCATION (Street		Rural Route Number,	
TED	4 Homicide determined	building, atc. (Spec	uny)			City or Town, Sta	10)		
COMPLET	290. CERTIFIER 1 CERTIFYING PNYSH	CIAN: To the best of my know	rledge, death necum	ed at the time date	and place, and du	e to the cause(e) and =	anner en eleted		
MP	anal and	R: On the basic of examination						tuse(a) and manner as state	ed.
	29b. SIGNATURE AND TITLE OF CENTRE	1							
BE	AND SIGNATURE AND TITLE OF GENTINE	R	MIN		29c. LICENSE NU	n & a	29d. DATE SI	GNED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATN (ITEM 27) (Tona	Print)	100	0 1	1 //	10175	

DHMH-16 Rev 1/89



	TE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIEN
CENTIFICATE OF DEATH REG. NO.	BISTRAR	CERTIFICATE OF DEATH REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)	L.		ICDIII.		2. DATE OF DEATH MONTH DA	Y YEA	3. TIME OF DEATH	
	DARLENE 4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	KEHL IF UNDER 1 YEAR	IF UNDER 24 HRS.	0.3 1.5 7. DATE OF BIRTH	1993	8:30 Am	
	216 60 3480		O YRS.	MONTHS DAYS	HOURS MIN.	5/4/52	We	ishington DO	
_	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH								
OTO	WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY								
DIRECTOR	100. STATE MD 100 COUNTY CE GEORGES HYATTING OF LOCATION								
	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZEN C	1 X YES 2 NO	
FUNERAL	6220 43rd AVE				20781		U.S	S.A.	
ВУ	11. MARITAL STATUS 1 Never Married XX Married 3 Vidowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 ZNO	If yes, sp		NIC ORIGIN? (Specify Yes in, Puerto Rican, etc.) y:	8	ACE — American Indian, lack, White, atc. pecity: WHITE	
ETED	15. DECEDENT'S EDUC (Specify only highest grade	USUAL OCCUPATION	ON st of working	166. KIND OF BUS	INESS/INDUSTR	Υ			
PLE	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 SECRETZ					M TOC	. LOCAL # 26		
COMPL	17. FATHER'S NAME (First, Middle, Last)	1711(1	16. MOTHER'S NA	ME (First, Middle, Melden)		,ALI # 20			
BE (CHARLES	Ε.	DARR			JOAN		ICOCK	
0	19a. INFORMANT'S NAME (Type/Print) SHELENE MARTIN		19b. MAILING SAI	ADDRESS (Street & ME AS 1	nd Number or Rural . 0 e	Route Number, City or Town	, State, Zip Code,		
	20a METHOD OF DISPOSITION 1 Burlal 2 Cremetion 3 Reme			OF DISPOSITION (Na			CATION — City o		
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIG		T. LIN		METERY		BRENTW	OOD, MD	
	22. NAME AND ADDRESS OF FACILITY TAKOMA FUNERAL HOME 254 CARROLL ST NW WASHINGTON, D.C. 20012								
RTIFICATION	IMMEDIATE CAUSE (Finel	2		r j.	No Ury	C M		Interval Between Onset and Death	
MEDICAL CE	PART II. Other significent condition	e contributing to deeth b	ut not reaulting	In the underlying	g ceuse given in	Part I. 24a. WAS AN PERFORI	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
AN:	25. WAS CASE REFERRED TO MEDICAL								
PHYSICI	EXAMINER?	HOSPITAL:	eatient 3 DDA	OTHER:	ACE OF DEATH (Ch	6 Other (Specify)			
ВУ РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJURY WO	URY AT RK? 'ES 2 NO	28d. DESCRIBE HOW IN	JURY OCCURED		
	2 Accident 3 Suicide 8 Could not be determined 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)							al Route Number,	
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.								
TO BE	MONTE THE OF CERTIFIER	ll			O.C.I			16/1993	
	30. NAME AND ADDRESS OF PERSON WHO WHO THE PILED (Month, Day, Year)	When mp	.11 Pen		et, Bal	timore, M	larylaı	nd 21201	
	MAR 17 '93	Julia Davidson	Mande 82						

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

URECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be hours after death with the State Dept. of Health Hygher prior burial, cremation, or removed accounts has notified as noted.

	1 - STATE REGISTRAR	STATE OF MARY		RTMENT OF			NTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last) Beulah		KOBYLARZ	7			DATE OF DEATH DA	1 0 0 3	3. TIME OF DEATH 11:00 p. M
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	E (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 F		DATE OF BIRTH		IRTHPLACE (State or Foreign
	210 76 0222	1 🗆 M 2 🔀 F	70 YRS.	MONTHS DAYS		IIN.	(Month, Day, Year) 1-17-192	a	ountry)
	218-76-8223 9a. FACILITY NAME (If not institution, give s	trast and number)		9h CITY TOW	OR LOCATION			9c. COUNTY C	est Virginia
Œ						OF DEATH			
DIRECTOR	Potomac Valley Nu	irsing cente	1:	Rockvi.	тте			Montgo	шету
l m	10a. STATE 10b. COUNT	10c. CIT	TY, TOWN OR LO	CATION				10d. INSIDE CITY LIMITS?	
	MD Mon	tgomery		Silver	Spring				1 YES 2 K NO
7	10e. STREET AND NUMBER			····	101, ZIP CODE			10g. CITIZEN	OF WHAT COUNTRY?
EB	1405 Milestone	Drive			20904			п.,	S.A.
BY FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVE		13. WAS D	ECENDENT OF H	ISPANIC O	PRIGIN? (Specify Yes	or No- 14. F	ACE - American Indian,
	1 Never Married 2 Married	FORCES? 1 YE			specify Cuban, N ES 2 K NO		uerto Rican, etc.)		Black, White, etc.
	3 Widowed 4 Divorced								White
E	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S	S USUAL OCCUPA work done during			16b. KIND OF BUS	SINESS/INDUSTR	TY
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	ise retired.)					
3 2	1		Work	er			Shelte	r Works	hop
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER	'S NAME (First, Middle, Maiden	Surname)	
BE	Luther	Vaught]	Hadie 1	Unknown	
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS (Street	et and Number or	Rurel Route	Number, City or Tow	n, State, Zip Code	n)
	Timothy R. Wien:	3	11141	Georgi	a Ave.,	#32	4, Wheat	on, MD.	20902
	20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rem		206. PLACE AND DAT				DATE 20c, LO	CATION — City	or Town, Stata
	4 Donation 5 Other (Specify)	Total Holl State	of cemetary, cremator	y Chape	1 Cemet	ery i	3/15 Dai	mascus,	MD.
S .	21 SIGNATURE OF FUNERAL SERVICE LI	CENSEE	4	22. NAME	AND ADDRESS	OF FACILIT		Funera	1 11
TO BE COM	Michael	D. Cel	lean	10 E	.Deer P	ark 1			rg,MD. 20877
CERTIFICATION	ahock, pr heart failure. iMMEDIATE CAUSE (Finei disease pr condition resulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	e. Cancer of DUE TO (OR A		DF):	stasis				interval Between Onset end Death 6 months
5 5	DART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24e, WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS								
PHYSICIAN: MEDICAL CE	PERFORMED? 1 YES 2 X NO OF								240. WENE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			PLACE OF DEAT	TH (Check	only one)		
SIC	1 TYES 2 NO	1 Inpatient 2 ER/C	Outpatient 3 🗆 DOA	OTHER:	ome 5 🗆 Resid	ience 6 🗆	Other (Specify)		
BY PHY	27. MANNER OF DEATH	26e. DATE OF INJUI (Month, Day, Yea		ME OF 28c.	INJURY AT WORK?	28	d. DESCRIBE HOW I	NJURY OCCURE	ED
BY F	1 Natural 5 Pending 2 Accident Investigation	(North, Day, 700			YES 2 N	ю			
	3 Suicide 6 Could not be 4 Homicide detarmined	28e. PLACE OF INJ building, etc. (5	URY — At home, farm, Specify)	, street, factory, o	ffice	26	f. LOCATION (Street City or Town, State)	and Number or R	ural Route Number,
MPLE	contact only	SICIAN: To the best of my ki							use(a) and manner as stated.
∈ Blu	296. SIGNATURE AND TITLE OF CERTIFIE		1	NI	29s. LICENS	E NUMBER	R	100000000000000000000000000000000000000	INED (Month, Day, Year)
	Mark	12	///	My	D00	120		Marc	h 11, 1993
2	30. NAME AND ADDRESS OF PERSON W				hoot	Mari	**1an 3 20	002	
	Walter E. Goozh, 31. DATE FILED (Month, Day, Year)	M.D. 2309 32. REGISTRAR'S S		a Ka. W	nearon,	mar	yrand 20	704	
	MAR 19 '93	Gilia Dav	idson-Randel	2					

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	E FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	s medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	E HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	E FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the d within 72 hours after death with the State Dept, of Heath and Mental Hygiene prior to burial, cremation, or removal.	RTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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hould

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME MIRIAM 2. DATE OF DEATH 3. TIME OF DEATH KYENZEL 6 4 M 3 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 92 YRS. 220-46-5877 1 | M 2 | F 07/03/1901 NewLexington, QH 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH PRINCE GEORGE'S 4913 TUCKERMON STREET RIVENDALE FUNERAL DIRECTOR RESIDENCE OF DE PRINCE GEOLOGES 10c. CITY, TOWN OR LOCATION RIVERDALE mo 1 YES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 4913 TUCKERMAN STREET 20737 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X10 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify: White 8 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compl Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 School Teacher Education notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jesse E. Powell Julia A. Baird BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Edward Kuenzel 7603 Eastern Avenue #2, Takoma Park, MD 20912 20s METHOD OF DISPOSITION
1 A Burlal 2 Cremation 3 Rem
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Fort Lincoln Cemetery 3/8/93 Brentwood, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 23. PART Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. Approximate IMMEDIATE CAUSE (Finel Onset and Death ARTONIOSCUENOTIC CARBUNAROUAR DISGRE disease or condition_ 23 shows any injury, or other traumatic event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): MEDICAL CERTIFICATION Sequentially llat conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (DR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

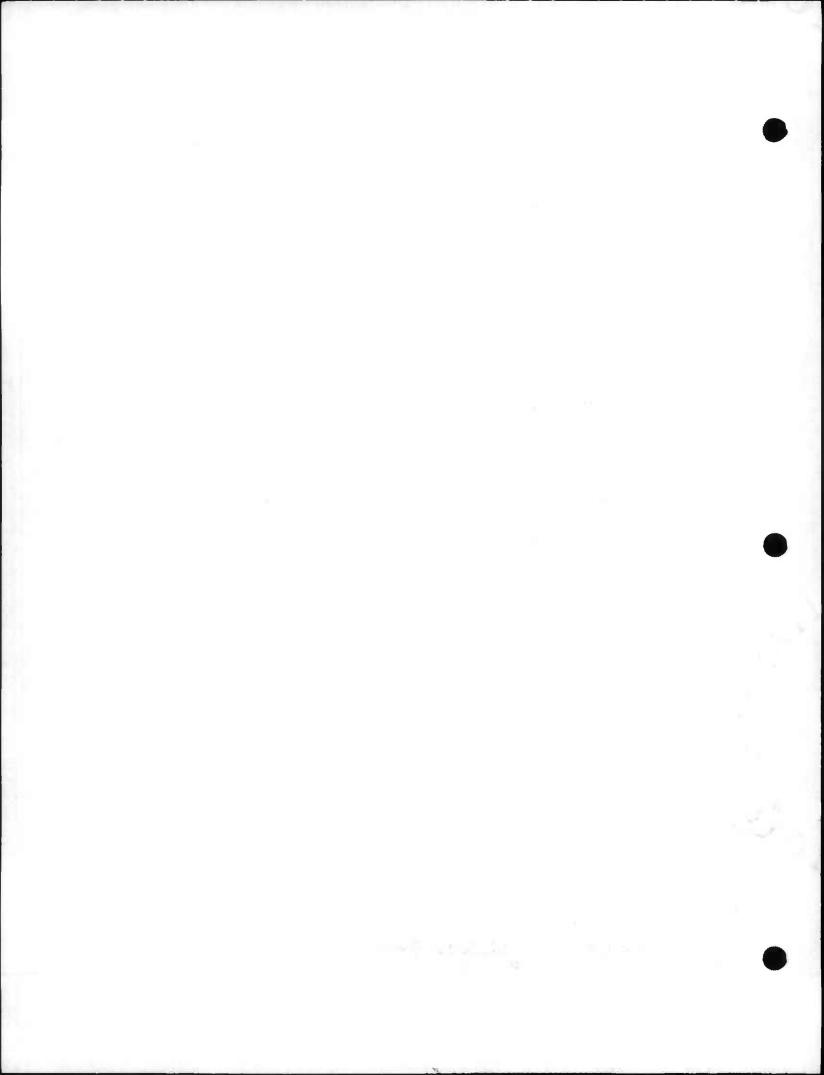
1 X YES 2 NO 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: g Home 5 Residence 6 - Other (Specify) marked, or 4 Nurs 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 5 Pending investige 1 Natural NIA 1 YES 2 NO BY 2 Accident 28a. PLACE DF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 6 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. COMPLE TO THE HOSPITAL TO THE FUNERAL C BE filed within 72 h 2 De MEDICAL EXAMINER: On the bests of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER Deputy Medical 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) Decore and 20185 2 WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4203 Queens sungled HyattsvikeMD 20781 ULE 32. REGISTRAR'S SIGNATURE

Illist certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

arted, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

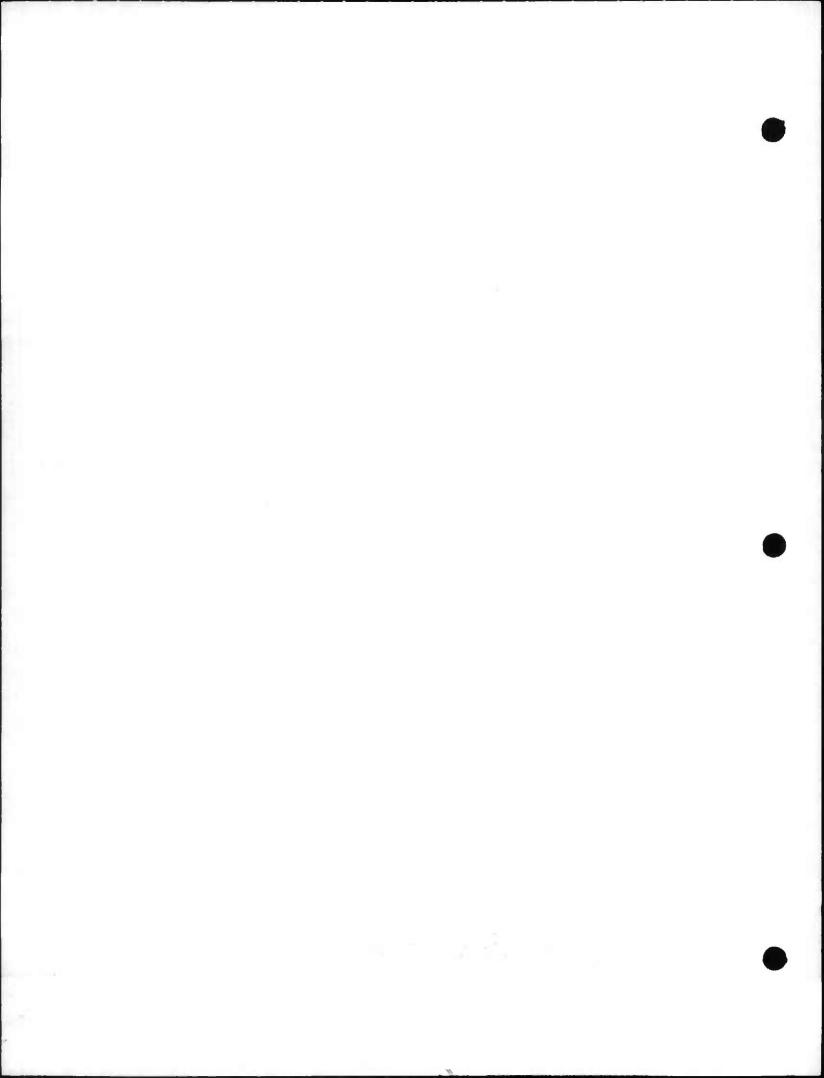
D.D. WEISS, IT. 31. DATE FILED (MOON), Doy, 1601) MAR 0 8 1993

	1 - FOR STATE REGISTRAR		STATE OF I					EALTH AND I	MENTA	AL HYGIEN REG. NO	-	13	08841
	1. DECEDENT'S NAME (First, Middle	o, Last)								E OF DEATH			3. TIME OF DEATH
	JEAN ADELI	NE K	IRSCHNE	R					MON	R 6 19	AY O 2	YEAR	0247 A M
	4. SOCIAL SECURITY NUMBER		S. SEX		. last birthday)	IF UNDER 1	1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	7.	8. BIRTH	PLACE (State or Foreign
	044-16-9293	1	□ M 2 🕢 F	68	YRS.	MONTHS	DAYE	HOURS MIN.		th, Day, Year) R 25 1	924	Countr	ECTICUT
	9a. FACILITY NAME (If not institution		9b. CITY,	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH									
DIRECTOR							BETHESDA MONTGOMERY						RY
ME	10e. STATE 10b.	COUNTY			10c. CI	TY, TOWN OF	R LOCATI	ION					10d. INSIDE CITY
5	MARYLAND PR	LINCE	GEORGE	1S	OXC	N HIL	1					- 4	LIMITS?
	10e. STREET AND NUMBER				1 0710	1111	-	ZIP CODE			10g. CITI	ZEN OF W	/HAT COUNTRY?
FUNERAL	5823 CHOCTAW D	RIVE					2	0745			LINLET	ED C	TATES
N	11. MARITAL STATUS		2. WAS DECEDEN			13. W		ENDENT OF HISPAN	NIC ORIGI	N7 (Specify Ve			- American Indian,
	1 Never Married 2 X Merrie	rd	FORCES? 1		X NO	17	yes, spe	cify Cuban, Mexica	in, Puerto	Rican, etc.)		Black	, White, etc.
В	3 Widowed 4 Divorced	-		WIT OIL DATES		1 '	☐ TES	2 NO Specifi	у.			Speci	WHITE
COMPLETED	15. DECEDENT (Specify only highe			16a	DECEDENT'S				16	b. KIND OF BU	SINESS/IND	USTRY	
Ē	Elementary/Secondary (0-12)		College (1-4 or 5	+)	(Give kind of life. Do NOT u	work done di se retired.)	unng mos	st of working					
4	12				CL	ERK			U.	S. GO	/FRNM	FNT	
Ö	17. FATHER'S NAME (First, Middle, L	Last)						18. MOTHER'S NA					
	WILBUR O'REIL	LY						LENA GR	AVE	LNE			
BE	19a. INFORMANT'S NAME (Type/Pri		_		19b. MAILING	ADDRESS	(Street or	nd Number or Rural i			vn, State, Zio	Code)	
5	WINSTEAD BRIGH	T KU	RSCHNER		5823 C	HOCTA	AW D	RIVE. OX	ON F	HLL.	4D 20	745	
Ü	20a, METHOD OF DISPOSITION 1 ☑ Burlal 2 ☐ Cremation 3			20b. PLA	CE AND DATE	OF DISPOSIT	TION (Nar	me of	DA	TE 20c. LC	CATION -	City or To	wn, State
	4 Donation 5 Other (Specif		II from State	_ Arli	ington	Nati	ona]	L Cemete:	ry3/	10/93	Arlin	igtor	ı, Va.
	21. SIGNATURE OF FUNERAL BER	VICE LIDER	SEE /	Λ	1			ID ADDRESS OF FA					
	> He	(/	1.2/							77			
	1111 20 20	> V_	180	1/4	1)		eorg	ge P. Ka	las				
-	23 PART I Enter the Assess		/ Ka	lex	<u>)</u>	6	eorg 160	ge P. Ka Oxon Hi	las 11 R	d. Oxo	n Hil	1, N	
	23. PART I. Enter the disease shock, of heart for iMMEDIATE CAUSE (Finel disease or condition resulting in death)	e, or cor allure. Lis	ORAL	_ MAXII	IIne. LLARY	not enter t	eorg 160 the mod	ge P. Ka Oxon Hi	las 11 R	d. Oxo	n Hil	1, N	Approximeta Interval Between Onset and Death
ATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	e., or cor allure. Lis	ORAL DUE TO	ise on each	LLARY	6: not enter t CANCE	eorg 160 the mod	ge P. Ka Oxon Hi	las 11 R	d. Oxo	n Hil	1, N	Approximeta interval Between
RTIFICATION	iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions,	e	ORAL DUE TO	_ MAXII	LLARY NSEQUENCE O	6 CANCE	eorg 160 the mod	ge P. Ka Oxon Hi	las 11 R	d. Oxo	n Hil	1, N	Approximeta interval Between
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	bd.	ORAL DUE TO	MAXII OR AS A COM OR AS A COM	LLARY SEQUENCE O	6. CANCE	eorg 160 the mod	ge P. Ka Oxon Hi de of dylng, suc	las 11 R	d. Oxo	n Hil	.1, M	Approximeta interval Between Onset and Death
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	bd.	ORAL DUE TO	MAXII OR AS A COM OR AS A COM	LLARY SEQUENCE O	6. CANCE	eorg 160 the mod	ge P. Ka Oxon Hi de of dylng, suc	las 11 R	d. Oxo	n Hilliratory arr	.1, M	Approximeta interval Between
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	bd.	ORAL DUE TO	MAXII OR AS A COM OR AS A COM	LLARY SEQUENCE O	6. CANCE	eorg 160 the mod	ge P. Ka Oxon Hi de of dylng, suc	las 11 R	d. Oxo	n Hilliratory arr	.1, M	Approximeta interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset Ons
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BE COMPLETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent conditions in the cause of the	d	ORAL DUE TO DUE TO DUE TO DUE TO DUE TO Contributing to 10 SPITAL: Inpetient 2 28e. DATE OF (Month, D) 28e. PLACE O building,	MAXII (OR AS A CON (OR AS A	Ine. LARY INSEQUENCE OF INSEQUENC	OTHER 1 OTHER 2 OTHER 3 JURY M street, factored at the time on, in my op	eorg 160 the mod R 26. PL: ing Home 28c. INJU 1 UT	Ox On Hi Ox On Hi Ox On Hi Ox On Hi Ox On Hi Ox On Hi Ox O	Part I. Part I. S Oth 28d. De	24a. WAS APPERFO 1XXYES TO TOWN, State PURPO(a) and ma	I AUTOPSY RMED? 2 MD INJURY OCC and Number	24b.	Approximeta interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset of Death?
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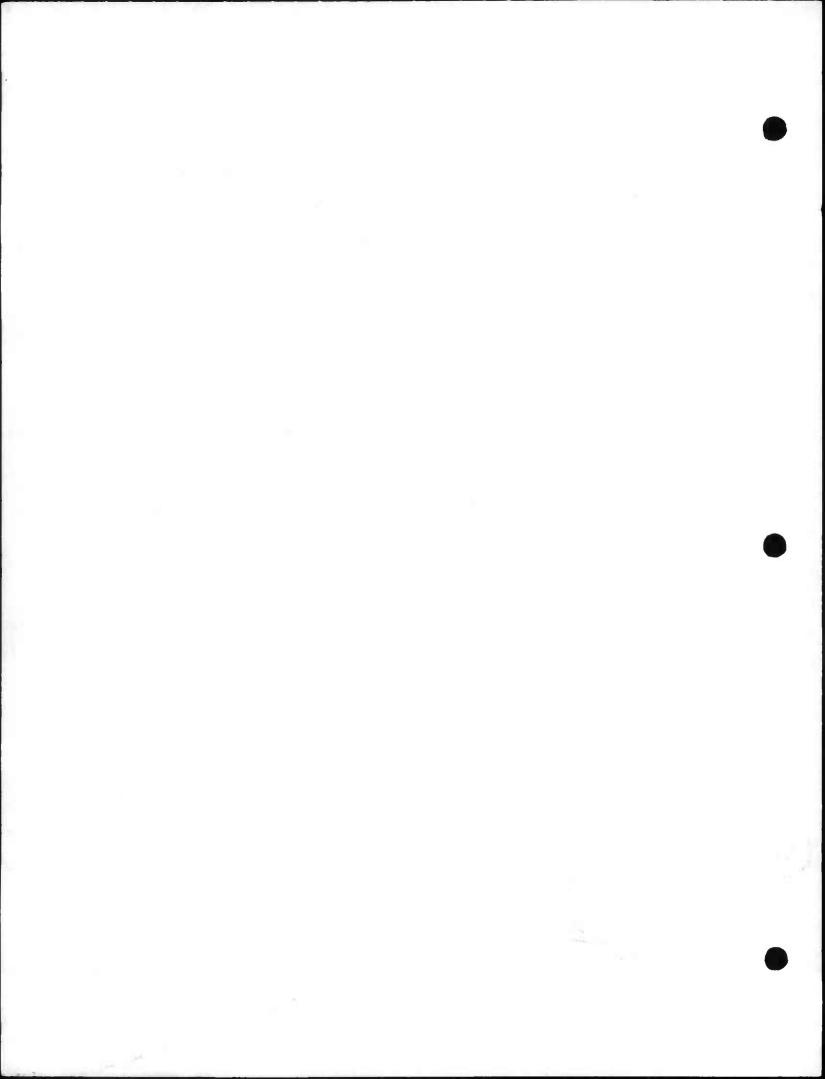
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50,	within
687	NUMBER PHYSICIAN: The law requires that the death certificate be executed within 24 ho
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Ö.	rtificate
ď.	ath ce
S O	the de
OH	that
REC	requires
AL	he law
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OF	PHYSICI
DIMISION OF VITAL RECORDS, P.O. BOX 68760	TENDING
2	ALTE ALTE

		1 - STATE REGISTRAR	STATE OF MARY		RTMENT OF H		MENTAL HYGIEN	E	00012		
	9	1. DECEDENT'S NAME (First, Middle, Lust)					2. DATE OF DEATH		3. TIME OF DEATH		
			GEORGE JOSE	PH KEEGAN	J. JR		MAR 3 19		6:30 A		
		4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	6. B	IRTHPLACE (State or Foreign		
		006-16-2859	1 M 2 D F	71 YRS.	MONTHS DAYS	HOURS MIN.	JUL 4 192		ountry) MAINE		
should	- 6	9a. FACILITY NAME (If not institution, give str	eet and number)	-	96. CITY, TOWN (OR LOCATION OF D		9c. COUNTY			
1, 2, 3	ECTOR	NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY RESIDENCE OF DECEDENT									
Pages	1 00 1	10a. STATE 10b. COUNTY		10c. CI	Y, TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS?		
permit.	□	MARYLAND PRIN	CE GEORGE'S		FORT WA	ASHINGTO	N		1 TES 2 NO		
	FUNERAL	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?		
DZO physician. burial-transit	買	1208 SWAN HARBO	UR CIRCLE			207	44	UNI	TED STATES		
DZO physician. burial-trar	5	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 7 YES		13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Yes in, Puerto Rican, etc.)	or No 14. I	RACE — American Indian, Black, White, etc.		
	BY	1 Never Married 2 X Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 TES	2 NO Specif	y:		Specify:		
			1943 - 1						WHITE		
or use	ETED	15. DECEDENT'S EDUC. (Specify only highest grade of		16a. DECEDENT'S (Give kind of life. Do NOT u	USUAL OCCUPATION Work done during mo	DN ast of working	18b. KINO OF BUS	HNESS/INDUSTI	RY		
ital d		Elementary/Secondary (0-12)	College (1-4 or 5+)	Me. Do NOT a	se reured.)						
AND he hospit detached once.	COMPL	CT FATIATING ALLASE ST. A ALLAS AS	5	II. S.	A F		DEFE				
oy the be det		17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)			
	出	GEORGE JOSEPH	KEEGAN SR				TRICE MARTI				
retained 5 should notified	일	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a		Route Number, City or Town		*		
ay be r		G.J.KEEGAN.III			MILL ST		CCOQUAN, VA	22125			
6 may be ector, page		20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remo	val from State 20	Ob. PLACE AND DATE emetery, crematory or o	OF DISPOSITION (Na other place)	nme of	DATE 20c. LO	CATION - City	or Town, Stats		
Page 6 al directo		4 Donation 5 Other (Specify)		Metropol	<u>itan Cre</u>	natory 3	-4-93 A	lexandr	ia, Virginia		
		21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE		Georg	DADORESS OF FA	las Funeral	Home			
r death. r death. r tunera	_ !	CHIT FIRES				-	11 Rd. Oxor		Md. 20745		
g 5 E 3		23. PART I. Enter the disesses, or co	emplications that cause	ed the death. Do	not enter the mo	de of dylng, suc	h as cerdlec or respi	ratory arrest,	Approximate		
Do o E		shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel Onset and Death									
24 E		disesse or condition									
rted within completely ial, cremati	1	resulting in death) a	DUE TO (OR AS	A CONSEQUENCE O	D-IFMPOK	AL AND C	OCCIPITAL H	EMORKH	AGIG		
executed and con o burial,	z	many recognition in Account		TMDADOW							
execute n and c to buria	임	Sequentisity list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):									
ficate be physician ne prior to	CATIO	cause. Enter UNDERLYING CAUSE (Disease or Injury									
nding phy Hyglene	RTIF	that initiated events DUE TO (OR AS A CONSEQUENCE OF):									
end the	ıwı	resulting in death) LAST									
, , , , ,	C	PART II. Other significant conditions	contributing to death	but not resulting	in the underlying	a ceuse aluen la	Bort I Day Mag Au	ALITTORION I	24b. WERE AUTOPSY FINDINGS		
			commonly to count	Dat Not resolung	in the uncertying	a canae diveil ili	PERFOR		AVAILABLE PRIOR TO		
law requires that as been signed by lept. of Health an 23 shows any	EDICA						1 X YES 2	□ NO	OF DEATH?		
requi	Σ						—		1 TYES 2 XNO		
	AN	25. WAS CASE REFERRED TO MEDICAL									
H 99 H	SICI	EXAMINER?	HOSPITAL:		OTHER:	ACE OF DEATH (Ch	eck only one)				
SICIAN: Th certificate the State	₹	1 YES 2 NO	1 Inpatient 2 ER/Ou 28s. DATE OF INJURY				6 Other (Specify)				
HE PHYSICIAN: This certifical Bath with the St marked, or it	РНҮ	1 X Natural 5 Pending	(Month, Day, Year)	28b. TIN	JURY WO	RK?	28d. DESCRIBE HOW IP	NJURY OCCURE	D		
	A	2 Accident Investigation	200 DI ACE OF IN HIS	W 44 h		YES 2 NO					
TTENO after d	유	3 Suicide 6 Could not be determined	28a, PLACE OF INJUF building, etc. (Sp	ecify)	street, factory, offic	•	281, LOCATION (Street a City or Town, State)	nd Number or Ru	iral Route Number,		
the ATTENOIS Theurs after des Item 28 Is n		SA. APPENDED									
A 100 PM	COMPLET		IAN: To the best of my kno								
	ő	2 MEDICAL EXAMINER	: On the basis of examinati	ion and/or investigation	on, in my opinion, d	eath occured at the	time, date and place, sno	d due to the ceu	use(s) and manner es stated.		
THE HOSPI THE EUNER filed within	w	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	MBER	29d. DATE SIG	NED (Month, Day, Year)		
5 5 5 M	0	S. D. north	of m.D.					> 3	-4-93		
	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	EATH (ITEM 27) (Type	, Print)	NATIONAL	L NAVAL MEI				
12)		S. D. NORTHROP, L	CDR, MC, US	SNR			A MD 20889-				
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	MATINE	. 00				-		
		MAR 0 8 1993	gena De	vidson-Rand	مالات				A		
			0				·				



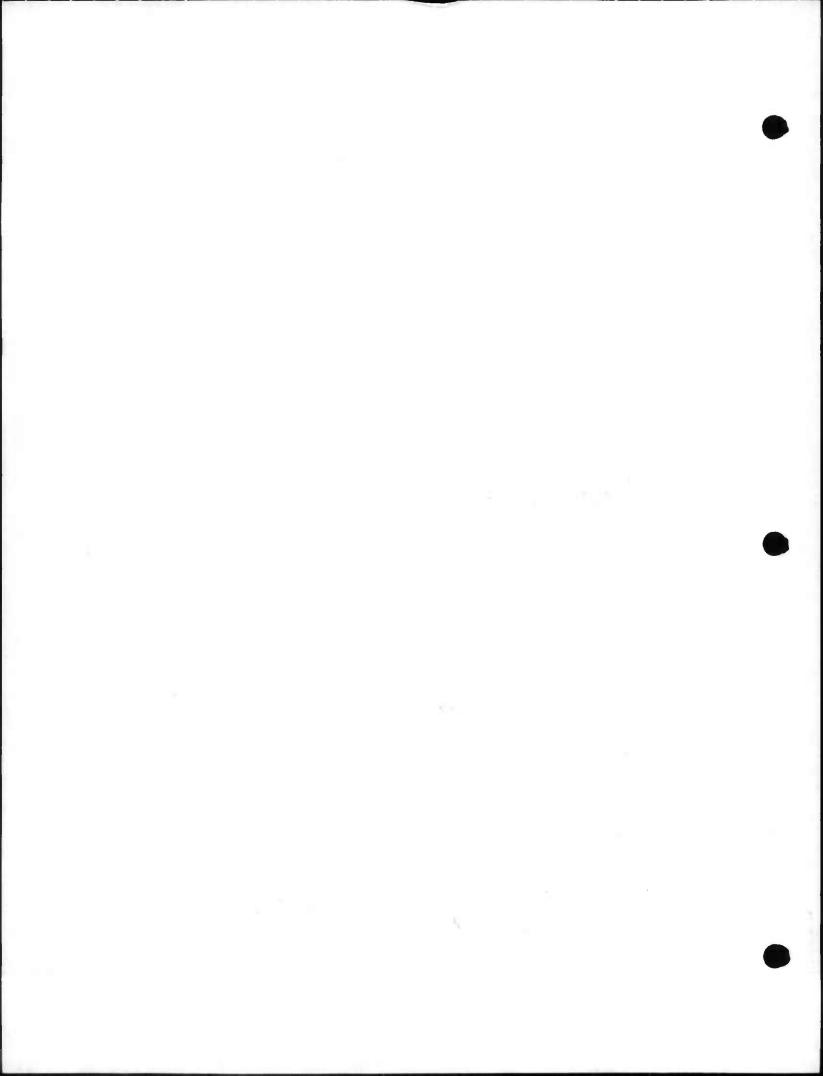
	•
	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
D	CEPTIFICATE OF DEATH

		1 - STATE REGISTRAR			CERTIF	ICATE	OF	DEATH	REG. NO			
		1. DECEDENT'S NAME (First, Middle, Last) ANNA	KINNEY						2. DATE OF DEATH	-	43	3. TIME OF DEATH
P		4. SOCIAL SECURITY NUMBER 219-12-1149	1 □ M 2 ½ F	6. AGE (In yrs. 80	lest birthday)	IF UNDER 1	YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH Feb. 1, 1		8. BIRTHP	Sylvania
. 2, 3 should	TOR	98. FACILITY NAME (If not institution, give s UNION MEMORIAL) RESIDENCE OF DECEDENT						ORE CITY	АТН		1time	
it. Pages 1.	DIRECTOR	10a. STATE 10b. COUNTY Florida Mart				y, town of ensen		each				10d. INSIDE CITY LIMITS? 1 YES 2 NO
ın. ransit permit.	FUNERAL	100. STREET AND NUMBER 147 Sharyon Lar	ne					33457		10g. CITIZEN OF WHAT COULUSA		
-0020 ding physician. the burial-transit	ВҰ	11. MARITAL STATUS 1 Never Married 2 X Married 3 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WI	YES 2	ARMED	lf.	yes, spe		IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	a or No-	14. RACE - Black, Specify:	- Amarican Indian, White, atc.
MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the burial notifiled at once.	PLETED	(Specify only highest grade Elementary/Secondary (0-12)	15. DECEDENT'S EDUCATION (Specify only highest grade completed) ntary/Secondary (0-12) College (1-4 or 5+)					ON st of working	16b. KIND OF BU		DUSTRY	
YLAND 2- by the hospital of 5 be detached for 1 at once.	E COMPL	17. FATHER'S NAME (First, Middle, Last) George Reuben I)ean		ales_			18. MOTHER'S NA Gladys	ME (First, Middle, Maider Ottoway T	1 Surname)		
	TO B	190. INFORMANT'S NAME (Type/Print) George E. Smith	1		196. MAILING 14969	Wing	street a	nd Number or Rural F Con Road	Roune Number, City or Tov Waynesbor	vn, State, Zip O, PE	code)	17268
e 6 ma ector, p		20a, METHOD OF OISPOSITION 1 M Buriel 2 Cremation 3 Remark 4 Departion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE		20b. PLA	CE AND OATE (n Men	nori	al Park	3/13 Hag	erstc	Olty or Town	n, state Mary Land
ALT death. F e funeral II. examin		Gerald M. S.	Muc	h		Ge Fu	eral Iner	d N. Min al Home	nnich 30 Ha	gerst	own,	nac Street Maryland
24 hours filled in the sion, or resited		23. PART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in daeth)	complications that List only one cause. ARDIF	e on aach i	ina.		ha mod	da of dying, suci	h aa cardiac or reap	iratory an	rest,	Approximats interval Between Onset and Death
P.O. BOX 6876 th certificate be executed ending physician and corr il Hygiene prior to burial, or other traumatic ex	TIFICATION	Sequentisily list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	BRADYCO SIP A	ARDIA or as a con DRTIC	SEOUENCE OF	typot exim		SION , LEPAIR	RENAL FAI	LURE, I	ARDS	
of the	11	PART II. Other significant condition	s contributing to d	death but no	ot resulting i	n tha und	eriying	cause given in	PERFO	RMED?	A	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE
REC requires een sign of Heat	N: MEDICAL								1 YES :	≥ KNO	0	OF DEATH?
Certificate has be the State Dept.	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER:		ACE OF OEATH (Che	6 Other (Specify)			
B PHY	ву РНУ	27. MANNER OF OEATH 1 Netural 5 Pending 2 Accident Investigation	28a. OATE OF II (Month, Day	NJURY	28b. TIM		8c. INJL WOI 1 Y	JRY AT	28d. OESCRIBE HOW			TINJURY
OR ATTENDING DIRECTOR: After hours after dea		3 Suicide 6 Could not be detarmined	28e. PLACE OF building, e	INJURY — At tc. (Specify)	home, farm, a	treet, factor	y, office		28f. LOCATION (Street City or Town, State	and Number	or Rural Rou	ste Number,
크스트	COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYSII (Check only one) 2 MEDICAL EXAMINE							to the cause(s) and ma time, data and place, ar			and manner sa stated.
TO THE HOSE TO THE FUNERA De filed within 7 IMPORTANT: I	TO BE	296. SIGNATURE AND TITLE OF CENTREEN	Ted .	MP		PE	p#	29c. LICENSE NUM AT 243 &91		29d. DAT	3-1	Month, Day, Year) 10-93
			RSITY PK	CWY	BALT		2	21218				
		31. DATE FILED (Month, Day, Year) SHART 5 1993	32. REGISTRAR		Market	L						



STATE OF MAR	YLAND / DEPARTMENT		MENTAL HYGIENS
	CERTIFICATE	OF DEATH	REG. NO.
IZMERT AND	CHEAD TETMI		

		FOR STATE REGISTRAR	STATE OF MARYLAI		MENT OF HI		ENTAL HYGIEN						
		1. DECEDENT'S NAME (First, Middle, Last)	KNEELAND SH	EAR LEIT			2. DATE OF DEATH MONTH DA	W _YI	3. TIME OF DEATH				
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In	Vrs. last birthday)	IF UNDER 1 YEAR	F 12005 11100	3 14						
		578-07-0591	1 ₹ M 2 □ F 88		NONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)				
3 should		Se. FACILITY NAME (If not institution, give st			9b. CITY, TOWN OF	LOCATION OF DEA	SEPT.3,19	9c. COUNTY	IRGINIA OF DEATH				
1, 2, 3 s	DIRECTOR	CIRCLE MANOR NURS	ING CENTER		KENS	INGTON		MONTG	OMERY				
sade	REC	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCATE	ON			10d. INSIDE CITY				
Hr. P		MARYLAND MON	TGOMERY		POTOMAC				1 YES 2 NO				
the burial-transit permit. Pages	ERAL	11506 REGENCY DRI	VE		107.	ZIP CODE			N OF WHAT COUNTRY?				
al-tran	FUN	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U				ORIGIN? (Specify Yes	or No- 14.	. RACE — American Indian.				
e bri	BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TYES			offy Cuben, Mexican, NO Specify:	Puerto Rican, etc.)		Black, White, etc. Specify:				
SS	ED B	15. DECEDENT'S EDUC	ATION 1	6a. DECEDENT'S U	SIAL OCCUPATION	-	16b, KIND OF BUS	HITE					
for use	ET	(Specify only highest grade (Elementary/Secondary (0-12)	completed) College (1-4 or 5 +)		rk done during most		IOU. KIND OF BUS	MESS/INDUS	TRY				
be	COMPL	12	I	FOREMAN	EMBASSY	DAIRY							
be detach at once.	Ö	17. FATHER'S NAME (First, Middle, Last)					E (First, Middle, Maiden :	,					
	BE	WILLIAM LEIT 19a. INFORMANT'S NAME (Type/Print)	Н	19h MAILINO A	DODESS (Charles		E MAY SHE						
5 should notified	유	WILLIAM E. LEITH	(SON)				TOMAC, MAR		20854				
r, page		20a. METHOD OF DISPOSITION 1 Burlal 2 X Cremetion 3 Remo	20b. P	LACE AND DATE OF	DISPOSITION (Nam				y or Town, State				
director, p		4 Donation 5 Other (Specify)	ME	TROPOLIT	AN CREMA			ANDRIA	A, VIRGINIA				
tuneral dir I. examiner		21. SIGNATURE OF FUNERAL SERVICE LICE				J. COLI	INS FUNER	AL HOM	ME. INC.				
the fu wal.		Mohelie	1, 100		500 UN	IVERSITY	BLVD.,W.	SIL.SP	PR.,MD 20901				
d in by the or removal medical		23. PART i. Enter the diseases, or or shock, or heart failure. L	inclications that caused to be only one cause on eac	he desth. Do no h line.	t enter the mod	e of dying, such	es cardiac or respi	ratory arrest	Approximate interval Between				
		iMMEDIATE CAUSE (Final disease or condition	1550						Onset and Death				
ompletely fille il, cremation, event, the		resulting in death) SEPTICEM BA DUE TO (OR AS A CONSEQUENCE OF):											
and com burial, natic en	Z	SEPTICEMEN DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING OUE TO (OR AS A CONSEQUENCE OF):											
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ng physi giene pr other t	IFIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A C	ONSEQUENCE OF):									
DE T	CERTI	resulting in death) LAST											
y the atte	AL C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS											
0 = -	SICA	A - 0			1		PERFOR	-	AMAILABLE PRIOR TO COMPLETION OF CAUSE				
Sign Hea	MEDIC	CASTROLATES	ECULTURY /	BRHAGE	,		_	,,	OF DEATH?				
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certificate has been the State Dept. of 1, or item 23 sho	ici/	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	CE OF DEATH (Checi							
the it	PHYSICI	1 TYES 2 DENO 27. MANNER OF DEATH	1 Inpetient 2 ER/Outpati	28b. TIME	OF 28c, INJU	5 Residence 6	Other (Specify)	JURY OCCUR	IED				
with with	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUI	RY WOR	K? S 2 NO							
		3 Suicide 6 Could not be	28e. PLACE OF INJURY — building, etc. (Specify	At home, farm, str	eet, factory, office	2	est. LOCATION (Street a City or Town, State)	nd Number or F	Rural Route Number,				
u	ETE.	4 Homicide determined											
32	COMPLI		IAN: To the best of my knowled						water and the second				
THE FUNE filed within PORTANT		29b, SIGNATURE AND TITLE OF CERTIFIE	: On the basis of examination a	ind/or investigation,									
TO THE FUNE be filed within IMPORTANT	BE	25th SIGHT ONE AND TITLE OF CENTIFIC	C. D.			29c. LICENSE NUMB	Le !	29d. DATE SI	IGNEO (Moreth, Day, Year)				
Fă	은	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, F	Print)	393 2	RIGG -	AF	1.5(1)				
		MARYW C. ST	LARGLE M.	<u>).</u>		KENSIN	FRAGUE) 29	895				
		31. DATE FILED (Month, Day, Year) MAR 16 93	32. REGISTRAN'S SIGNAT	URE . XI									
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YEAR

1993

3. TIME OF DEATN

DHMH-18 Rev 1/89

6:30 P

REG. NO. 2. DATE OF DEATH

MARCH 11,

FOR STATE REGISTRAR

KENT

1. DECEDENT'S NAME (First, Middle, Last)

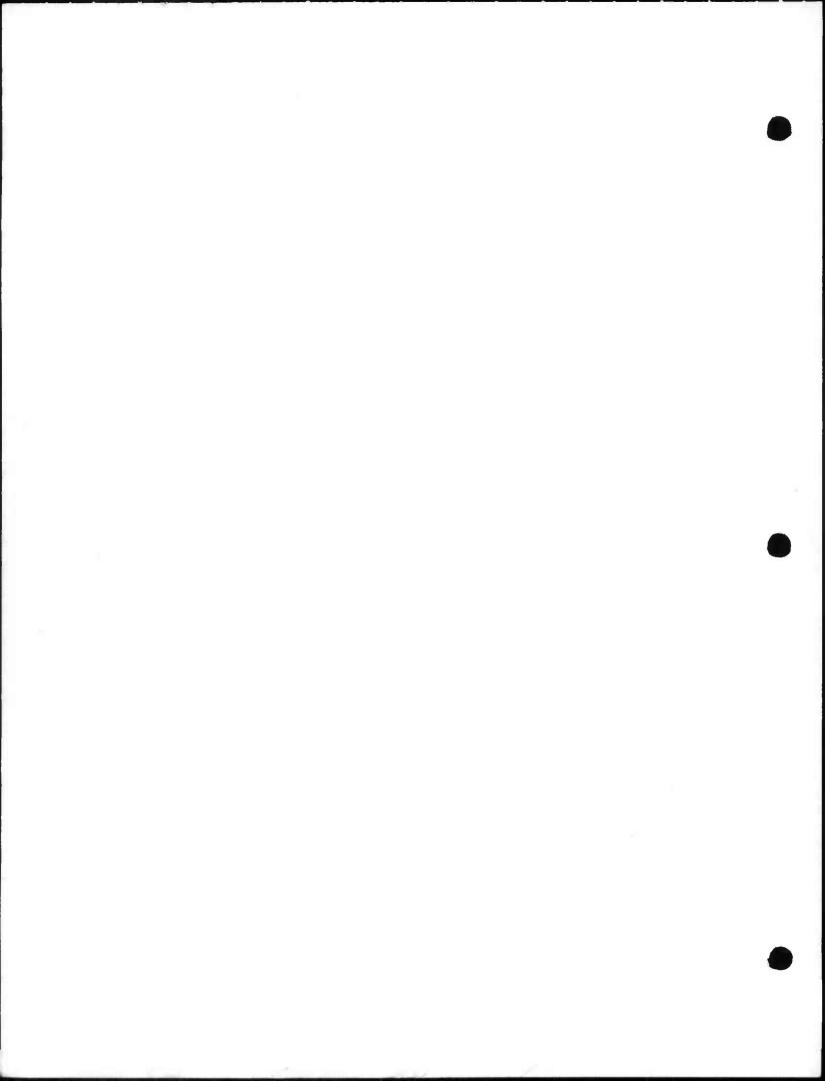
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4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS HOURS 1 K M 2 | F 176-24-6845 SEPT.8,1920 WASHINGTON.D.C use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 15072 HASLEMERE COURT SILVER SPRING MONTGOMERY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY SILVER SPRING 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 15072 HASLEMERE COURT 20906 USA within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEOENT, EVER IN U.S. ARMED FORCES? 1 \(\tilde{\Delta} \) YES 2 \(\tilde{\Delta} \) NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES ΒY 3 Widowed 4 Divorced Specify: WHITE ETED | 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Ď Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 4 CONTRACTING OFFICER FEDERAL GOVERNMENT once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) by the funeral director, page 5 should be ĕ WILLIAM H. LINKINS MABEL A. KENT notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MARIE E. LINKINS (WIFE) 15072 HASLEMERE COURT SILVER SPRING, MARYLAND 20906 pe METHOD OF DISPOSITION Burlal 2 Cremation 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must $\begin{array}{c} {\it cemetery, cremetory or other place}, \\ {\it GATE OF} \\ {\it MEAVEN} \\ {\it CEMETERY} \\ \end{array}$ 3/15 Donation 5 - Other (Specify). SILVER SPRING, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY teven FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL.SPR., MD. 20901 medicai 23. PART I. Enter the disesses, or complications that caused the deeth. Do not anter the mode of dying, such as cerdisc or respiretory arrest, filled in by shock, or heart feilure. Liet only one cause on each line. 6 Interval Batwee IMMEDIATE CAUSE (Finel Onset and Beath the attending physician and completely fille Mental Hygiene prior to burial, cremation, the diseese or condition manth resulting in death) event. DUE TO (OR AS & CONSEQUENCE OF): TIL LUMA executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF If any, leading to immediate 9 cause. Enter UNDERLYING certificate CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initieted events resulting in death) LAST 0 death (item 23 shows any Injury, PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS has been signed by 1 Dept. of Health and AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 1 🗌 YES 2 🗍 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) tertificate the State HOSPITAL: OTHER 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 0 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked WITH ä 1 Natural 2 Accident 1 YES 2 NO BY death After ATTENDING 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY -- At home, farm, street, factory, .10 3 Suicide 6 Could not be COMPLETED DIRECTOR Yours after 23 4 Homicide Item 8 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. SPITAL KERAL Nn 72 h 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29h SIGNATURE AND TITLE OPPERTIFIER res. 29c. LICENSE NUMBER 品 29d. DATE SIGNED (Month Day, Your) suu a. D21463 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2102 MEDICAL PARK DRIVE BRUCE A. SILVER, M.D. SILVER SPRING. MD. 31. DATE FILED (Morith, Dey, Year) MAR 16 '93 32 REGISTRAN'S SIGNATURE
G'MA NAMADON-MORDELL

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



93

ITEM: 9a, PER MEO G-698 4/14/93 t.t

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH VEAD Stephanie Lanterman 03 1993 10 4:39 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 🗌 M 2 💢 F 216-64-5866 38 Dec. 15,1954 Washington, DC should 90. FACILITY NAME SUBURBAN HOSPITAL 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 BETHESDA MONTGOMERY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Bethesda 1 - YES 2 NO detached for use as the burial-transit permit, FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8502 Whittier Blvd. 20817 United States be retained by the hospital or attending physician, ge 5 should be detached for use as the bunal-tran 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2
IF YES, GIVE WAR OR OATES 1 K Never Married 2 Married 1 YES 2X XNO Specify B Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY maleted) Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Assistant Registrar Advanced Education/F.A.E.S 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) Gretchen Gingher John V. Lanterman BE funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John V. Lanterman 8502 Whittier Blvd., Bethesda, MD 20817 pe uted within 24 hours after death. Page 6 may L completely filled in by the funeral director, pag flal, cremation, or removal. 20a. METHOD OF DISPOSITION
1 □ Burlal 2X X Cremation 3 □ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 3/16/93 OATE 20c. LOCATION — City or Town, State must Montgomery Crematorium, Inc. 4 Donation 5 Other (Specify) Bethesda, Maryland medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00348 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cerdiac or respiratory arrest, Approximate shock, or haart failure. List only ona cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** the disease pr condition This doubt care was cular & 50008 event, resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760, executed the attending physician and con Mental Hygiene prior to burial, traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 SPITAL OR ATTENDING PHYSICIAN: The law requires that the death PART إلم Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? any 1 YES 2 NO Shows s certificate has been si th the State Dept. of He id, or Item 23 show TOYES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 DXYES 2 □ NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) this c. 26h TIME OF 28c. INJURY AT marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO After t BY Accident 28e. PLACE OF INJURY - At home, farm, street, factory, office 8 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) hours after d 8 Could not be COMPLETED 4 Homicide 29a. CERTIFIER
(Check only 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(a) and manner as stated. FUNERAL within 72 t IMPORTANT: 11 2 🖔 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(a) and menner as stated. 296. SHUATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE THE 03/11/1993 O.C.M.E. 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DIXON Penn Street, Baltimore, Maryland M.D. 21201 31. DATE FILED (Month, Day, 32. REGISTRAR'S SIGNATURE
Suns Davidson Randall

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE COURT, T.O. BOX 63.03, BALLINGTE, MANIEMED A1213-0020	in 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should	nation, or removal.	, the medical examiner must be notified at once.	
The second of th	To TH HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ROTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete	be althe within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumetic event, the medical examiner must be notified at ence.	

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART			MENTAL	HYGIEN	E					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH	_		3. TIME OF DEATH			
2	PAULINE	LIPSEN)				MONTH		a a	ZEAR 3	11:15 AM			
			yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTH			LACE (State or Foreign			
		□ M 2 😿 F	· //	MONTHS DAYS	HOURS MIN.	(Month	5/1904		Country)	RUMANIA			
118	9a. FACILITY NAME (If not Institution, give street	t end number)		9b. CITY, TOWN	OR LOCATION OF D	EATH		9c. COUNT					
DIRECTOR	CIRCLE MANOR N	URSING HOME		KENSINGTON						MONTGOMERY			
HE	10s. STATE 10s. COUNTY		10c. CITY,	TOWN OR LOC	ATION				il.	IOd. INSIDE CITY			
	MARYLAND MONTO	GOMERY	KEN	SINGTON					YES 2 NO				
FUNERAL	10231 CARROLL	PLACE		3	01. ZIP CODE 2089	5				STATES			
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. 14, RACE -									- American Indian			
	1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Cuban, Moxican, Puerto Rican, etc.) Black, W									White, etc.			
BY	3XXWidowed 4 Divorced									WHITE			
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	ION	16a. DECEDENT'S U			16b.	KIND OF BUS	BINESS/INDUS	STRY				
m		College (1-4 or 5 +)	life. Do NOT use	ork done during n retired.)	iost of working								
릴	8		HOMEMAKI	ER			OV	N HOM	E				
5	17. FATHER'S NAME (First, Middle, Last)			_	16. MOTHER'S NA	AME (First, A	fiddle, Meiden	Surname)					
	UNKNOWN				ESTHER		CONNER						
BE	19s. INFORMANT'S NAME (Type/Print)		19b. MAILING A	ADDRESS (Street	end Number or Rural	Route Numb	er City or Town	State Zin C	ndel.				
2	CHARLES B. LIP	SEN (SON)								o.c. 20009			
	20s. METHOD OF DISPOSITION	206	PLACEANDDATEO			OATE		CATION — CH					
	20s METHOD OF DISPOSITION 1 X Surfal 2	from State Come			AL GARDE								
	21. SIGNATURE OF PUNERAL SERVICE DICEN		MG DAVID		ND ADDRESS OF F		J FE	TIPO C	nukt	H, VIRGINIA			
	· UCT	(4)					MEMOR	RIAL C	HAPI	ELS, INC.			
	Hay M	Juse		1170	ROCKVILL	E PIK	E - RO	CKVIL	LE,	MD.20852			
	23. PART I. Enter the diseases, or corr shock, or hear; fellure. Lis	plicatione that ceused	the death. Do no	t enter the m	ode of dying, suc	ch ea card	iec or respi	retory arres	ıt,	Approximate			
- 1	IMMEDIATE CAUSE (FI	t only one ceuse on ea	cn line.							Interval Between Onset and Death			
- 1													
	disease or condition resulting in death) a. MASSIUE CELESCAL INFACCT DUE TO (OR AS A CONSEQUENCE OF): CERESCONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
-	resulting in death) a. MAJSIUR CEREBLAL INFARCT ONE WELL DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions b. CEREBLOVASCUCAL WELFICIANCY Y/LS												
ੁ	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF)			1000	7			+7/			
¥ I	cause. Enter UNDERLYING						•			1			
Ĕ	CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A	CONSEQUENCE OF)	:						1			
CERTIFICATION	resulting in desth) LAST												
4	PART ii. Other eignificant conditione c			the underlying	ng ceuse given in	Part i.	24s. WAS AN			VERE AUTOPSY FINDINGS			
8	METASTATIC	LUNG C	ANCEL				1 YES 2			COMPLETION OF CAUSE OF DEATH?			
WE								, ~		YES 2 NO			
PHYSICIAN: MEDIC													
₹	25. WAS CASE REFERRED TO MEDICAL			26. 1	LACE OF OEATH (C	heck only on	9)		_				
ဒ္ဓ		OSPITAL:		OTHER:	me 5 🗆 Residence	& C Other	(Conside)						
Ŧ	27. MANNER OF DEATH	28a. DATE OF INJURY	28b, TIME		JURY AT	_	CRIBE HOW II	JURY OCCU	RED				
- 1	1 Netural 5 Pending	(Month, Day, Year)	INJU	RY W	ORK? YES 2 NO								
A A	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY	- At home, ferm, etc			261 1 004	TION (Street e	and Number of	Dural Da	uto Mumbas			
	4 Homicide datermined	building, etc. (Specif	y)	out, restory, our			or Town, State)	ING PROPERTY OF	nurai no	Ne Number,			
<u> </u>	200 CERTIFIER			_									
COMPLETED		N: To the bast of my knowle											
Š	2 MEDICAL EXAMINER: C	In the basie of examination	end/or investigation.	in my opinion,	death occured at the	e time, date	and place, and	d due to the	ceuse(e)	and manner as stated.			
ш	29b. SIGNATURE AND TITLE OF CERTIFIER	-			29c. LICENSE NU	MBER		29d. DATE S	SIGNEO P	Wonth, Day, Year)			
∞ ∥	Martine 8h	and			DOR	944		13	le 19	73			
임	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	H (ITEM 27) (Type, F	H(nt) 2-	172 50	me	47 A	مار	-				
	MALTIN C. SHX	Rose m	1)	-	CURIAL	7704	470	7 7	A.C.	1			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	TURE			~	7-7	0	,				
	MAR 16 '93	Lucia Davidano	Day . 20										

DIVISION OF VITAL RECORDS, P.O. BOX 68760, O. BATTENDING PHYSICIAN: The law requires that the death certificate be executed within a DIRECTOR: After this certificate as been signed by the attending physician and completely burs after death with the State Dept. of Health and Mental Hygiene prior burial, cremaral them 28 is marked, or filter 23 shows any injury, or other traumatic event.	BALTIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	NERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
TO HE COSPITAL TO PE WITHING TO IMPORTANTE II	DIVISION OF VITAL RECORDS, P.O. BOX 68760,	INCHER HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO ACCOUNT AND THE COMPLETED SET THE CONTROL OF THE STATE OF THE STANDING PHYSICIAN AND COMPLETED FILLED IN THE INFORMATION OF THE STATE DEPT. OF THE STATE DEPT. OF THE STATE DEPT OF THE STATE DEPT.	IMPORTANT: Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	FOR 1 - STATE REGISTRAR	STATE OF		CER		TMENT O				MENTAL	HYGIE				
ł	1. DECEDENT'S NAME (First, Middle, I				1			-		2. DATE MONTH	OF DEATH	DAY	YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (III	yrs. last bir		IF UNDER 1 Y	FAR	IF UNDER 2	A 1495	7 DATE	OF BIRTH	(-	a pipti	IPLACE (State or Foreign	
	361-07-1508	1 🔀 M 2 🗆 F			YRS.			HOURS	MIN.	(Month	Day, Year)	1012	Count		
	9a. FACILITY NAME (If not institution,			80		9b. CITY, TO	WN OR	LOCATIO	V OF DE		L Z/,	_	INTY OF D		
œ										AIN		100			
5	HOLY CROSS HOS					SILV	EK	SPRI	NG			MON	MONTGOMERY		
DIRECTOR	10e. STATE 10b. CO	UNTY		11	Oc. CITY	, TOWN OR L	OCATIO	ON						10d. INSIDE CITY LIMITS?	
	MARYLAND	MONTGOMERY			5	SILVER	SP	RING						1 YES 2 NO	
FUNERAL	10e. STREET AND NUMBER						10f. 2	ZIP CODE				10g. CI	IZEN OF	WHAT COUNTRY?	
ER	11475 COLUMBIA	PIKE #D-7						209	04			USA			
5	11. MARITAL STATUS	12. WAS DECEDE	NT EVER IN	U.S. ARMED	D						? (Specify Y	es or No-	14. RACI	E — American Indian, k, White, etc.	
ВУГ	1 Never Married 2 1 Married 3 Widowed 4 Divorced	FORCES? IF YES, GIVE						NO NO		n, Puerto F	lican, etc.)		Spec		
			39-19										WHI	TE	
TE	15. DECEDENT'S (Specify only highest			(Give k	kind of w	USUAL OCCU				16b.	KIND OF BI	USINESS/IN	DUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	+)			e retired.)	m							1	
M	12 17. FATHER'S NAME (First, Middle, Las.			CLERK	ζ.	POS	_	SER							
							- 1	18. MOTHE	R'S NAI	WE (First, A	ficiolle, Maide	n Surneme)			
BE	JACOB I.TEV 19e. INFORMANT'S NAME (Type/Print)	ENS		To a decident							W				
9	MIMMIE LIEVENS	(WIFE	`			ADDRESS (SI								MD 00001	
									上 #]					MD 20904	
20s. METHOD OF DISPOSITION 1															
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	_ [ME	TROPO)LT1			ADDRESS		13/1.] ALE	XANDR	IA,	VIRGINIA	
	· Steven	Stynd	2			FRAN	CIS	J.	COL	LINS	FUNE				
	23. PART I. Enter the diseeses,	or complications th	at caused	the death	. Do n	ot enter the	UNI	VERS	T T Y	BLVI	lac or me	SIL.	SPK.	, MD . 20901 Approximate	
	shock, or heart fall iMMEDIATE CAUSE (Final	ure. Liat only one ce	use Dn ea	ch line.									, ,	Interval Between Onset and Death	
	disease or condition		0		6	000		1	Ch. 1		0			Oliset and Death	
	resulting in death)	mDUE TO	O (OR AS A					-ec-	0.0		an	CON	34.		
2	DUE TO (OR AS A CONSEQUENCE OF):														
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A	CONSEQUE	NCE OF):									
S	cause. Enter UNDERLYING CAUSE (Disease or injury	с													
	that initiated events	DUE TO	(DR AS A	CONSEQUE	NCE OF):									
E	resulting in death) LAST	d													
0	PART II. Other eignificent cond	itions contributing to	death bu	t ont reau	ulting is	n the under	dylan (ceuse als	wan in	Part I	24s. WAS A	N ALCYDROV		. WERE AUTOPSY FINDINGS	
3						, the direct	·ymg	couse gi	VOII 111	ant t.		RMED?	240	AMILABLE PRIOR TO COMPLETION OF CAUSE	
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를 디	EXAMINER?	HOSPITAL:	Man .			OTHER:					,				
¥	27. MANNER OF DEATH	1 Inpatient 2	9	-	Bb. TIME	4 Nursing	Home : INJUF		dence		(Specify) CRIBE HOW	W # 1577 0.0	NO. INC.		
	→ Netural 5 Pending	(Month,	Day, Year)	-	INJ	JRY	WOR	K?		20G. DEŞ	CHIBE HOW	INJUNY OC	COMED		
À	2 Accident Investigat	28a PLACE	OF IN ILIEV	At home	farm o	treet, factory,		S 2 🗌	NO	004 1 004	70001 (De				
9	3 Suicide 6 Coutd no 4 Homicide determine	building building	, atc. (Specif	y) ~	restrii, S	neer, rectory,	OTHER				TION (Street or Town, State		r or Hural I	Route Number,	
	29a, CERTIFIER						_								
COMPLET	(Check only	HYSICIAN: To the best of													
8	MEDICAL EXA	MINER: On the beels of	examination	and/or Inve	atigation	n, in my opini	on, dea	th occured	at the	time, date	and place, s	end due to t	he cause(s	e) and menner as stated.	
BE	296. SIGNATURE AND TITLE OF CERT	SFIER					2	29c. LICEN	SE NUM	BER		29d. DA	TE SIGNED	(Month, Day, Year)	
10		Don't		_		~		De	36	De	16	I ▶.	3	-11-63	
F	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAL	SE OF DEA	TH (ITEM 27	7) (Туре,	Print)							130	Kendo has	
	cdhis	1 aca	10	2		-	5	215	1	50 6	-0-	Sins		A00	

32. REGISTRAR'S SIGNATURE
Julia Davidson Bundare

31. DATE FILED (Month, Day, Year)
MAR 17 93

3,00 8.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT

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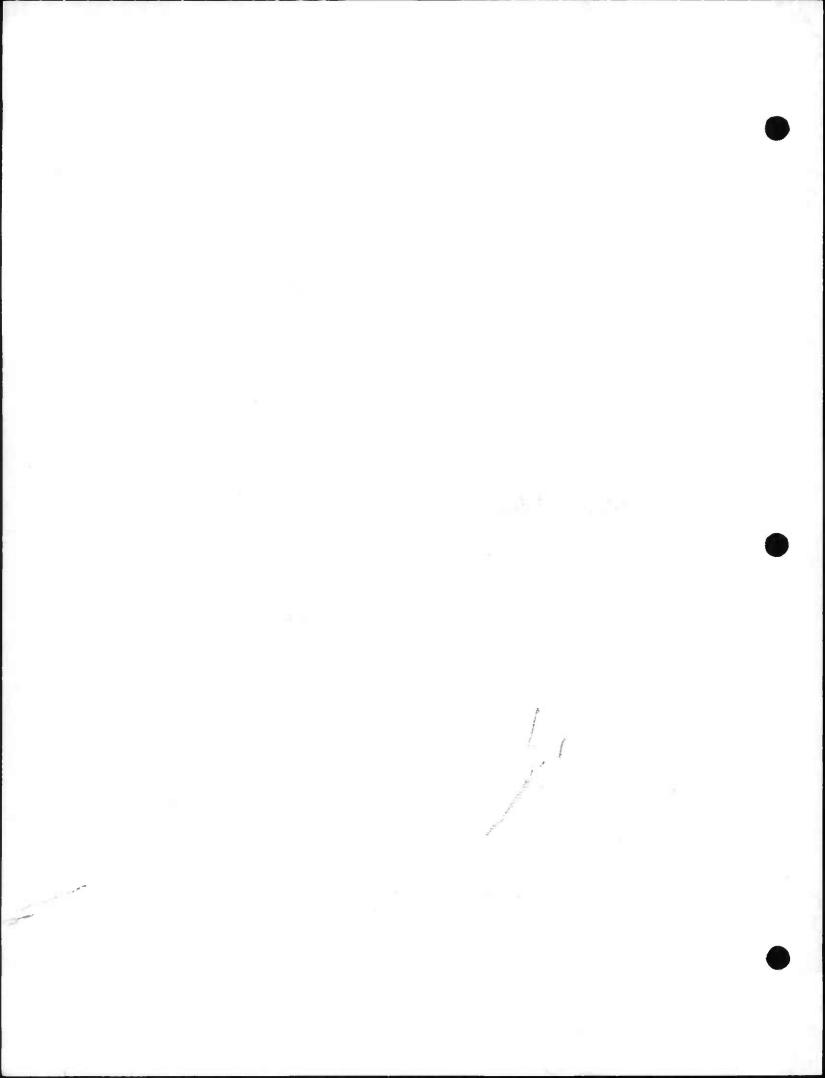
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32. REGISTRAR'S BIGNATURE
Funda Davidson frances

ITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	5 should be detached for use as the burial-trans	72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	. If flow 28 is marked or flow 22 shows any injury or other teaments areal the modified as an efficient at any
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t permit. Pages 1, 2, 3 should

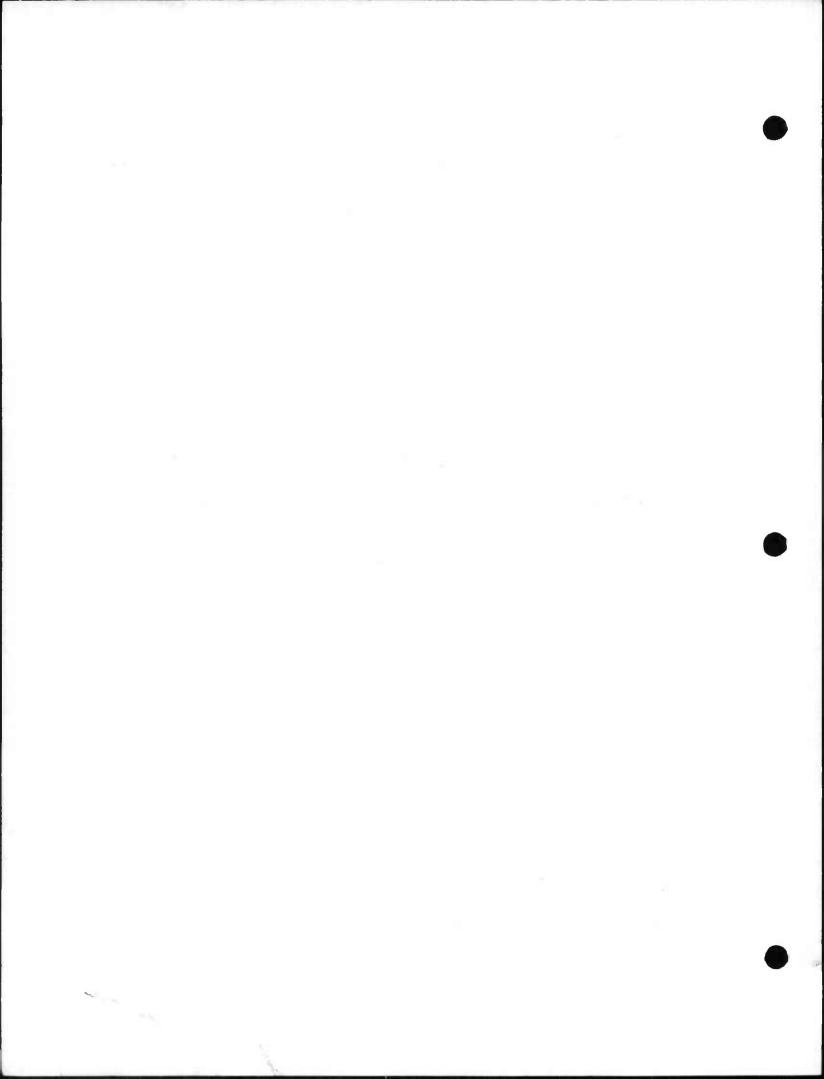
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 14 MONTH ()3 Maria Nunziata Leo 11:50a M 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) Oct 23 6. AGE (In vrs. lest birthdev) IF UNDER I YEAR 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 🗌 M 2 💢 F 214-06-5559 16 YRS 1976 Washington, DC 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 12913 Grenoble Drive Rockville Montgomery 10a. STATE 10b COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Rockville 1 X YES 2 NO FUNERAL 10a. STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 12913 Grenoble Drive 20853 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yes, specify Cuban, Maxican, Puerto Rican, etc.)
 T YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 10 Student 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Filippo A. Leo Maddalena Toscano BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 12913 Grenoble Dr. Rockville, MD. 20853 Maddalena Leo 20a. METHOD OF DISPOSITION
1 M Burial 2 □ Cremation 3 □ Ra 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Stata emetery, cremetory or Gate of on 5/1 Other (Specify) 03-18-93 Silver Spring, MD. Heaven 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 20904 11800 New Hampshire Ave. Silver Spring, MD ses, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximata interval Between IMMEDIATE CAUSE (Finel Onset and Death Zin Stem Herniztion disease or condition resulting in death) MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING iguza CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? MAN ARI F PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA me 5 Pasidence 8 Other (Specify) 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 3 Suicida 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER
(Chack note) 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) end manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner as stated. BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 93 2 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type



ANDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans ONISION OF VITAL RECORDS, P.O. BOX 68760, D.D. DAL CH. R.C. HOLD BLAY SEQUENT THE Law requires that the death certificate be executed within 1

BALTIMORE, MARYLAND 21215-0020

[Gree kind of work done during most of working part of the completed] 17. FATHER'S NAME (First, Middle, Last) HAROLD 19a. INFORMANT'S NAME (TyperPrint) HAROLD LUNENFELD 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City PATRIC) 19c. METHOD OF DISPOSITION 20c. METHOD OF DISPOSITION 20c	OR 1993 11:41 P S. BHRTHPLACE (State or Foreign Country) Y 4, 1962 NEW YORK 9c. COUNTY OF DEATH PRINCE GEORGES 10d. INSIDE CITY LIMITS? 1										
FILTZABETH 4. SOCIAL SECURITY NUMBER 213 88 6174 1	108 1993 11:41 P TH Interior Interio										
213 88 6174 1 M 2 X F 30 VRS. MONTHS DAYS MUN. JULY 9a. FACILITY NAME (if not institution, give street and number) 9a. FACILITY NAME (if not institution, give street and number) 2401 57TH AVENUE RESIDENCE OF DECEDENT 10a. STATE 10b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10c. CITY, TOWN OR LOCATION CHEVERLY 10c. CITY, TOWN OR LOCATION CHEVERLY 10c. CITY, TOWN OR LOCATION CHEVERLY 10d. STREET AND NUMBER 2401 57th AVE 11. MARITAL STATUS XX Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT VEYER IN U.S. ARMED FORCES? 1 YES 2 NO, If YES, GIVE WAR OR DATES 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working WIND Work done during most of working 17. FATHER'S NAME (First, Middle, Last) HAROLD LUNENFELD 18a. MOTHER'S NAME (First, Middle, Last) HAROLD LUNENFELD 19b. MAILING ADDRESS (Street and Number or Rural Route Number. City 143 4 CROFTON PARKWAY, C 20b. PLACE AND DATE OF DISPOSITION (Name of Specify) 10c. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION OF DEATH CHEVERLY 10d. CITY, TOWN OR LOCATION (Give kind of work done during most of working most of working of working of the death of the death of the during most of working of the death of the during most of working of the du	10d. INSIDE CITY LIMITS? 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. City Yes or No- 14. RACE - American Indian, Black, White, etc. Specify: WHITE WHI										
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21. SIGNATURE OF FUNERAL SOM CE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
an instance of their in											
TAKOMA FUNERAL HOME 25 CARROLL N.W. WASHINGTON, D.C. 20012											
IMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): 24a. 9											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 Ves 2 No 24b. WERE AUTOPSY FIRM AMILABLE PRIOR COMPLETION OF COMPLETION											
Z S. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 V YES 2 NO											
HOSPITAL: 1 YES 2 NO 1 Inpetiant 2 ER/Outpetiant 3 DOA 4 Nursing Home 5 Y Residence 8 Other (Special Properties)	(v)										
D. II	HOW INJURY OCCURED										
2 Accident Investigation M 1 YES 2X NO SUBJE	CT SHOT										
3 Suicide a Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	Street and Number of Burn Route Number, State) H AVENUE										
29a. CERTIFIER (Check only one) 29a. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) as MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place.	nd manner as stated.										
296. LICENSE NUMBER 29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) • 03 / 09 / 1993										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	1. 03/09/1993										
MAR 12 '93 MAR 12 '93 MAR 12 '93 MAR 12 '93 MAR 12 '93	, Maryland 21201										



TO THE HOSPITAL OR ATTEMENT PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

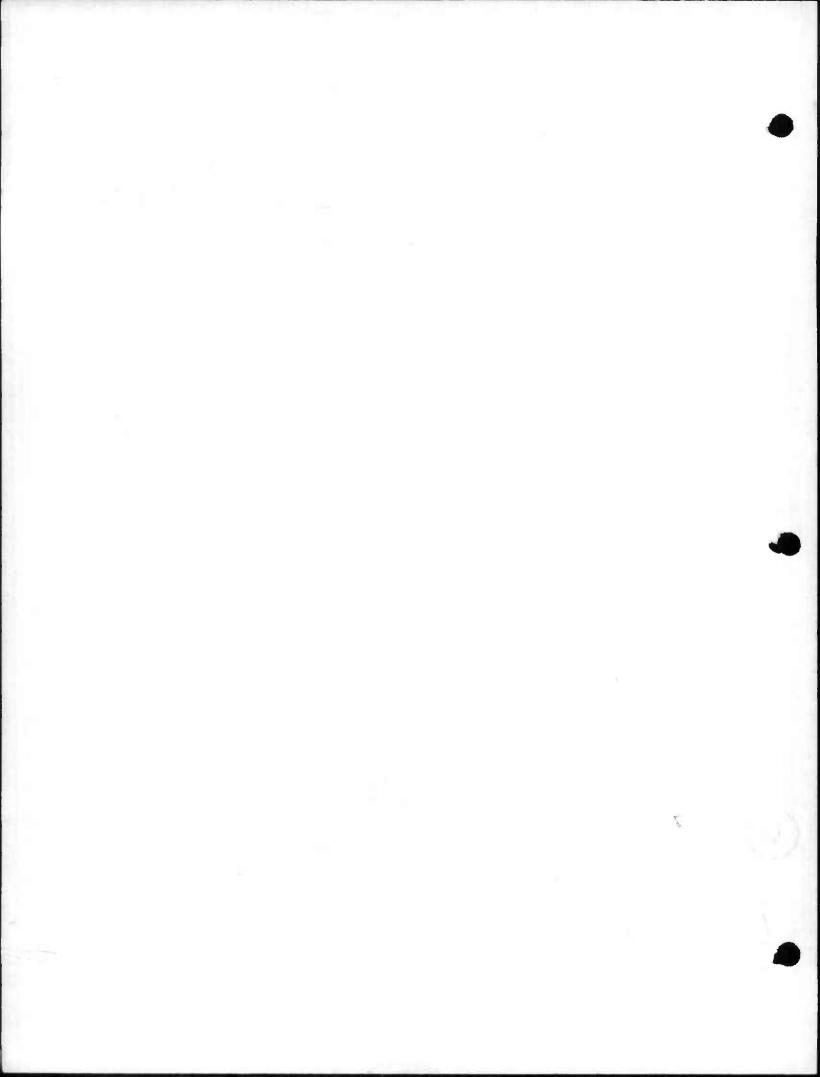
_	TIEGISTIAN			LOTTE	CALL	· Or	DEM	111	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Las	1)							2. DATE OF DEATH MONTH D		YEAR	3. TIME OF DEATH
	John	Edward I	inahan						March 16			3:00 P. M
- 1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7 DATE OF BIRTH		8. BIRTH	IPLACE (State or Foreign
	067-07-5688	1 🔯 M 2 🗌 F	79	YRS.	MONTHS	DAYS	HOURS	MIN,	(Month, Day, Year) Oct. 5, 1	913	New	York
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY.	TOWN	OR LOCATION	ON OF DE			INTY OF D	
۳			nton		40.71							
DIRECTOR	Potomac Valley	varsing Ce	enter		Rock	VII	Te			Mon	tgome	ry
ا پي	10a. STATE 10b. COU	VTY.		10c. CIT	Y, TOWN O	R LOCA	TION					10d. INSIDE CITY
声	Maryland Mon	tgomery		Roc	kvil	le						LIMITS?
	10e. STREET AND NUMBER	,				10	f. ZIP CODE	E		10a, CIT	IZEN OF Y	WHAT COUNTRY?
FUNERAL	1335 Potomac Va	llav Rd				2	0850			U.S.		
ŽΙ	11. MARITAL STATUS		IT EVED IN ILE	ADMED	T 49. W			F 140044	IIC ORIGIN? (Specify Yes		_	
[1 Never Married 2 Married	12. WAS DECEDED FORCES?		NO	H	yes, s	pecify Cuba	n, Mexica	n, Puerto Rican, etc.)	or No-	Black	E — American Indian, k, White, etc.
M A	3 📉 Widowed 4 🗌 Divorced	WWT T	MAR OR DATES		1	∐ YES	2 X NO	Specify	r:		Speci	White
	15. DECEDENT'S E		16a, I	DECEDENT'S	USUAL OC	CUPATI	ON		16b. KIND OF BUS	INFEC/IN	DUSTRY	WIIICC
COMPLETED	(Specify only highest gri	College (1-4 or 5		(Give kind of a	work done d	luring m	ost of workin	g		JII LOO/111	2001111	
ᆲ	12	College (1-4 of 5		chinis	t t				Tool En	rino	rino	Co
≶	17. FATHER'S NAME (First, Middle, Last)		Tiac	JIIIII	, .		10 140774	UEDIC MAI	ME (First, Middle, Melden		ELTHE	,
										Sumame)		
BE	James E. Linahai	1		and the same	-		Mary					
2									Route Number, City or Tow	-		
	Marie Linahan					-		Chevy	Chase, M			
	20a. METHOD OF DISPOSITION 1 N Buriel 2 □ Cremetion 3 N Re	moval from State		eremetory or o		TION /N	eme of				City or To	O CHARLE
	4 Donation 5 Other (Specify)	_ Calva			3/23 Woodside, New York							
	21. SIGNATURE OF FUNERAL SERVICE	UCEMBEE)			De.	VO.	ND ADDRES	SS OF FAC	Home			
-4	7.6.(THE			1000					tho	- n h	g, MD 20877
ahock, or heart failure. List only one cause on sech line. IMMEDIATE CAUSE (Exial disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									rea	y	9 years	
5												1
N: MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO. 24b. WERE AUTOPSY FRIDINGS ANIABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO.											
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL					26. P	LACE OF DE	EATH (Che	sch ontriane)			
8 I	1 TES 2 NO	HOSPITAL:	ER/Outpatient	3 🗆 00A	9XHER	ine Hoe	ne 6 FT Re	nidence	8 ☐ Other (Specify)			
=	27. MANNER OF DEATH	28s. DATE OF	INJURY	28b. TIM	E OF	28c. IN.	TA YRU	T	284, DESCRIBE HOW I	NJURY OC	CURED	
_	1 Pending	(Month, E	lay, Mari	INJ	URY M		YES 2	NO.				- 1
2 Achident									nd Numbe	r or Runal R	curte Number	
ED	6 Homicide 6 Could not b	building.	etc. (Specify)					- 1	City or Town, State)			
COMPLE	O'M) 2 1 MEDICAL ENAME	ER: On the basis of							to the cause(s) and man			and menner as stated.
4	296. SIGNATURE AND TILE OF CENTS	YEV	11	1/10	11		19c. LICE	NSE NUM	men .	29d. DAT	E SYGNED	(Magth, Day, Year)
2	- wall	4	1/	IN	1/		VC	110	20	▶3	118	193
-	30. NAME AND ADDRESS OF PERSON Y							- 11	with the second		1	1
	Walter E. Goozh					, W	heato	n, l	Maryland 20	902		
	MAR 19 °93	32 ABBUSTAN	Davidson-	Mandal	2							

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OF VITAL RECORDS, P.O.	mail Deliver Of all. The last committee that the death could
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• Mer this certificate has been signed by the attending physician and or math with the State Dept. of Health and Mental Hygiene prior to buria is marked, or Item 23 shows any injury, or other traumatic

to begin to include the processor within their begins of the processor by the hospital of distribute physics	the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial		
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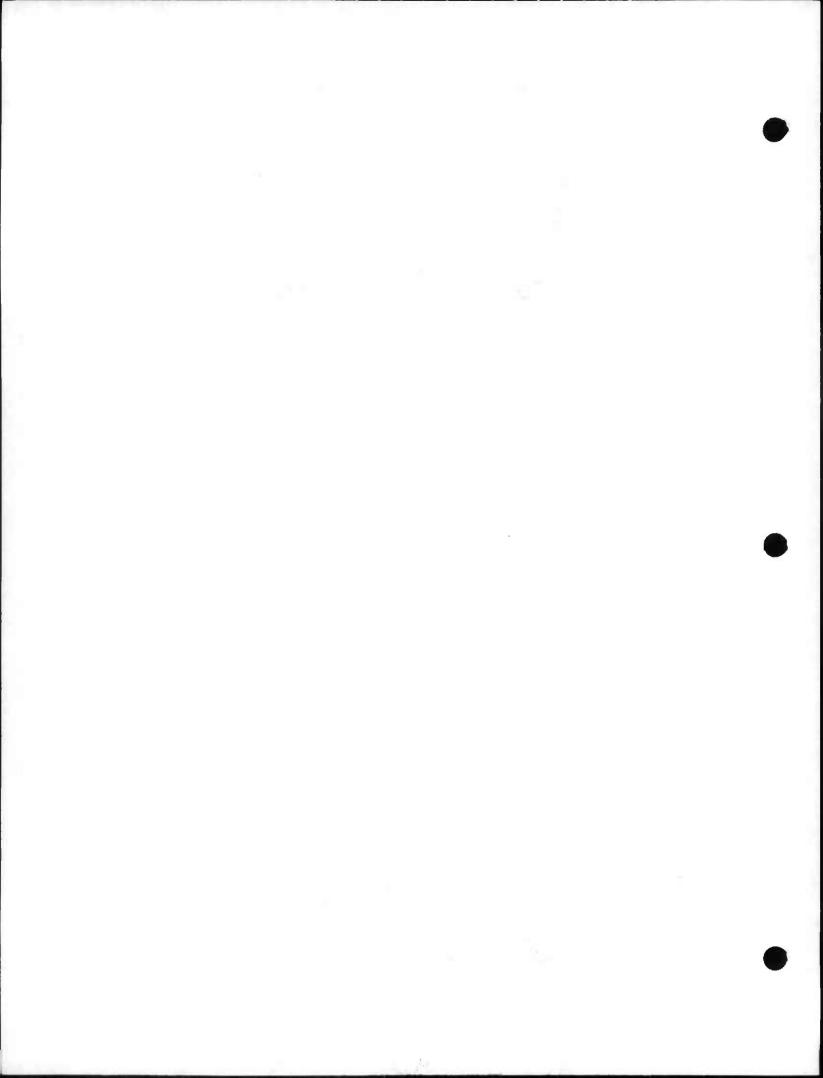
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTMENT OF H		NTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	Lanc			DATE OF DEATH DAY	3 93	3. TIME OF DEATH
15	4. SOCIAL SECURITY NUMBER 334 - 04 - 41.59	8. SEX 8. AGE (In yra. In	YRS. WONTHS DAYS		DATE OF BIRTH (Month, Day, Year) 9 - 29-	0.3	BIRTHPLACE (State or Foreign Country)
TOR	9a. FACILITY NAME (If not institution, give stree	sing Canto	Orou	R LOCATION OF DEATH		9c. COUNTY	J-ANSdel
DIRECTOR	10a. STATE 10b. COUNTY Mary and Phine	. Arundel	10c. CITY, TOWN OR LOCAT	10N 51/1/1/e)			10d. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	1454 Fair field	1 L000 RC	101.	ZIP CODE		10g. CITIZEN	of WHAT COUNTRY? ed States
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 Y IF YES, GIVE WAR OR DATES		ENDENT OF HISPANIC Cocify Cuban, Mexican, P 2 NO Specify:	ORIGIN? (Specify Year verio Rican, etc.)	or No- 14.	RACE — American Indian, Black, Whita, etc.
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondery (0-12)	mpleted) (DECEDENT'S USUAL OCCUPATION (Give kind of work done during most to the Do NOT use retired.)	N st of working	18b. KIND OF BUS	INESS/INDUST	RY PRY
COMP	17. FATHER'S NAME (First, Middle, Lest)		100 K	18. MOTHER'S NAME	(First, Middle, Maiden S	furname)	
TO BE	19m INFORMANT'S NAME (Type/Print)	2/100	19b. MAILING ADDRESS (Street a	nd Number or Rural Route	O () W () Number, City or Town	State, Zip Coo	1 1/1
۲	20e, METHOD OF DISPOSITION 1 Source 2 Cremation 3 Remove	20b. PLAC	E OF DISPOSITION (Name of cent	1+C/S	LANC)	ATION - City	or Toyen, State
	4 Donetion 5 Other (Specify)	GIE	nwood L'e	METERY ID ADDRESS OF FACILI	TYLLWYNOS	John	gton DC
	Aprice &	duard.	2 3720	5 Old.	Silver	41116	I suitinud
	23. PART I. Enter the diseases, pr con shock, pr heart failure. List iMMEDIATE CAUSE (Fine) disease or condition resulting in death) a.	at only one cause on each M	allers	ary Q	e cardiac or respir	atory screet	Interval Between
NOI	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A CONS	W	1			pareer
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST	DUE TO (OR AS A CONS	EOUENCE OF):				
AL CE	PART II. Other significant conditions	contributing to death but no	t resulting in the underlying	g cause given in Par	rt i. 24s. WAS AN A		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC	2 00.01	Os. Celo	ddov		1 TES 2		COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PL OTHER:	ACE OF DEATH (Check	only one)		
HYSI	1 TYES 2 NO	28e. DATE OF INJURY	3 DOA 4 Nursing Hom	e 5 Realdance 8 D	Other (Specify)	JURY OCCUR	ED
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY WO	PK?			
	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — At I building, etc. (Specify)	home, farm, street, factory, office	28	H. LOCATION (Street e City or Town, State)	nd Number or i	Rural Route Number,
COMPLETED	one)	AN: To the best of my knowledge, On the beels of examination end/o					suse(a) and manner on stated.
8	29b. SIGNATURE AND TITLE OF CERTIFIER)		29c, LICENSE NUMBE	3-8	29d. DATE SI	GNED (Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (IT	TEM 27) (Type, Print)	L. V.		7	1
	31. DATE FILED MAR 0 9 199	32. REGISTRAR'S SIGNATURE	n-Pandall				



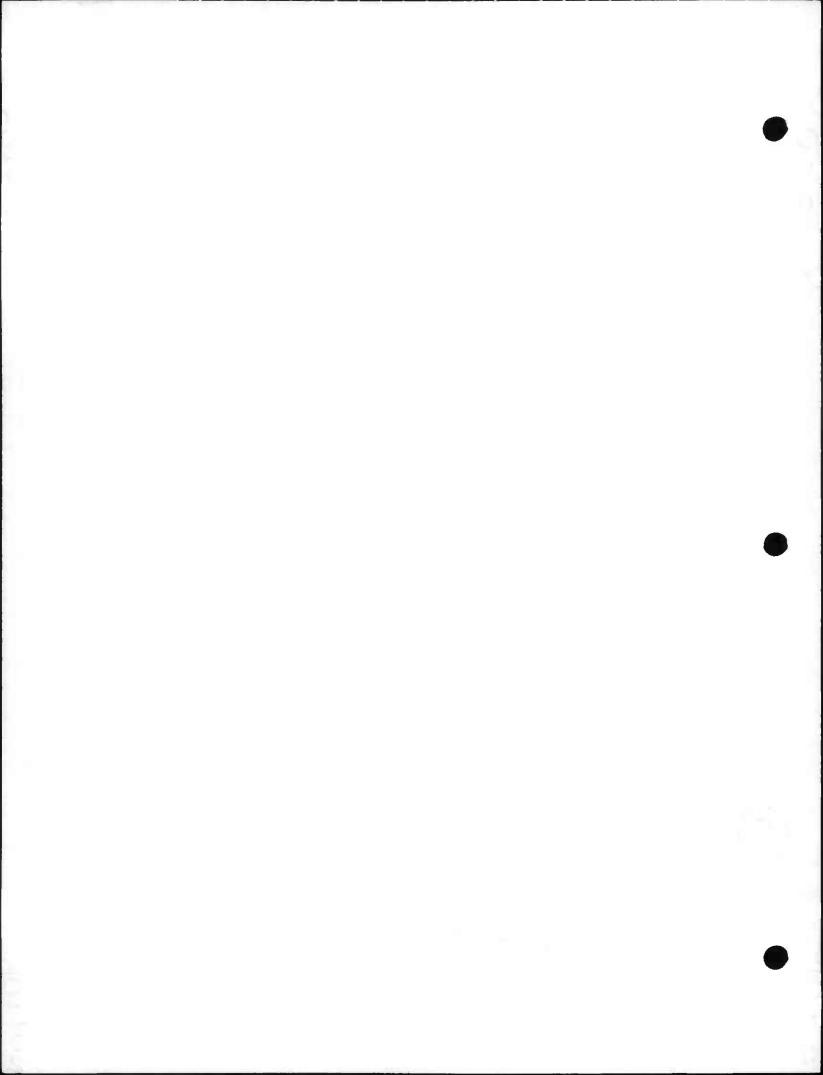
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

after death. Page 6 may be retained by the hospital or attending physician.	y the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 shous loval.	cal examiner must be notified at once.	
TO THE HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	HEGISTRAH			ERIIF	CALE	UF	DEAL	П	R	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Las			TTO	EON.				2. DATE OF D	DEATH DA	W.	YEAR	3. TIME OF DEATH
		istine		LIS	LON			_	MARCH		1993		2:18 A M
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. In		IF UNDER 1	YEAR DAYS	HOURS	24 HRS.	7. DATE OF B (Month_Pm)	HPTH v. Year)		Country)	LACE (State or Foreign
	577-26-8231	1 □ M 2 💢 🗜	83	YRS.					May 29	, 19			nacla.
ا _م ا	9a. FACILITY NAME (If not institution, give	ŕ	AT				R LOCATIO	ON OF DEA	ATH	D		NTY OF DE	
DIRECTOR	DOCTORS COMMUN	ITY HOSPIT	AL		LANHAM PRINCE GEORGE'S								
ñ	10a. STATE 10b. COUN	TY	10c, CIT	c, CITY, TOWN OR LOCATION 10d. INSIDE CITY								10d. INSIDE CITY	
	Maryland Prin	ce George'	New	Carr	oll	ton						LIMITS?	
A.	10e. STREET AND NUMBER					10f.	ZIP CODE				10g. CITI	ZEN OF WI	HAT COUNTRY?
FUNERAL	6414 86th Avenu	е			20784								
5	11. MARITAL STATUS	12. WAS OECEDENT FORCES? 1			13. W	AS OECE	NDENT O	F HISPANI	C ORIGIN? (S	pecify Yes	or No-	14. RACE	- American Indian, White, etc.
ВУ	1 Never Married 2 Married 3 X Widowed 4 Divorced	IF YES, GIVE W		NO				Specify:	, Puerto Rican	, etc.)		Specify	*
		1	1										WIIICE
COMPLETED	15. DECEDENT'S Ed (Specify only highest gra	de completed)	2	ECEDENT'S Give kind of vie. Do NOT us	VORK done du	ring mos	N it of workin	g			COOK	200	County
7	Elementary/Secondary (0-12)	College (1-4 or 5+)		afete								ge s ucati	
N.	17. FATHER'S NAME (First, Middle, Last)						-	ED'S NAM	IE (First, Middle			ucati	LOIT
	Dennis Gillis					- 1			lacNei		Surnemej		
BE	19a. INFORMANT'S NAME (Type/Print)		19	96. MAILING	ADDRESS	(Street ar			oute Number, C		State Zin	Code	
임	Mary Liston Holl	and	1						rollto			,	20784
	20s. METHOD OF DISPOSITION		20b. PLACE	ANDDATE	OF DISPOSIT	ION (Nar	ne of		DATE	20c. LO		City or Tow	
	NXBurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		Gate	of H	her place) eaver	Ce	m	3-12	2-93	Sil	ver	Sprin	ng, Maryland
	21. SIGNATURE OF FUNERAL SERVICE	LICENSES /						S OF FAC					
	· Klb	Olla	ini	Rendon/Hale Lanham Funeral Home 9013 Annapolis Rd., Lanham, Maryland 20706								nd 20706	
	23. PART I. Enter the diseases, D	complications that	caused the d	eath. Do n									Approximate
1	IMMEDIATE CAUSE (Final	. List only one ceus	e on eech lin				eneneti			- 12000	100	200	interval Between Onset and Death
	disease or condition		cardea	11	dura	- he	the	mie.					/ /
	resulting in death)	DUE TO (Carden	EQUENCE OF	7):	-							10
z	venes mustes vultures	b	hyper OR AS A CONSE	tens	uón								10
E	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS CONSE	QUENCE OF	7:		0	_	-	0			
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	C	CONG	estes	~	-1	na	it	fur	lun	(3yrs,
	that initiated events resulting in death) LAST	DOE TO (art	QUENCE OF	·);	1	4-	4	16				> 10 . 00
CERTIFICATION		d											1040
	PART ii. Other significent condition						ceuse g	iven in P	Part i. 24a	. WAS AN	AUTOPSY		WERE AUTOPSY FINDINGS
EDICAL		initial	5	Ler	Fre				_ 10	YES 2	-	1 3	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME	engetal	100	westy	- (-012	72)					7		1 YES 2 NO
ä				-									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:		ACE OF DE	EATH (Chec	ck only one)				
YSI	1 TYES 2 NO	1 Inpetient 2 🗆		3 🗆 DOA			5 🗆 Re	sidence 8	Other (Spe	ecify)			
표	27. MANNER OF OEATH 1 Netural 5 Pending	28a. DATE OF I (Month, Da		28b. TIMI INJ	URY	Bc. INJU	RK?	10000	28d. DESCRIE	BE HOW IN	JURY OCC	CURED	
B	2 Accident Investigation				М		ES 2 _						
8	3 Suicide 6 Could not b	25e. PLACE OF building, e	INJURY — At he rc. (Specify)	ome, 1erm, s	treet, factor	ry, office			281. LOCATION	N (Street a wn, State)	nd Number	or Rural Ro	ute Number,
H.	29a. CERTIFIER												
4	(Check only CERTIFYING PHY	SICIAN: To the best of n											
COMPLETED		NER: On the basis of ex					ath occur	ed at the ti	lme, data and	place, and	d due to th	e cause(a)	and manner as atsted.
BE	296. SIGNATURE AND TITLE OF CERTIF	Bretch	n Atte	nding	2 May	7.	MD.	NSE NUME	BER COL	3			Month, Day, Year) —9 3
2	30. NAME AND ADDRESS OF PERSON Y		E OF DEATH (ITE										
	David A. B.	oet-cher	-, MO	7	143	00	G-1	llan	+ Fo	x L	4,	#118	10 20715 Bruie
ļ	31. DATE FILED (Month, Day, Year)	32. REGISTRAF											/
	MAK I 0 1993	John Davidson	- Randal	2									
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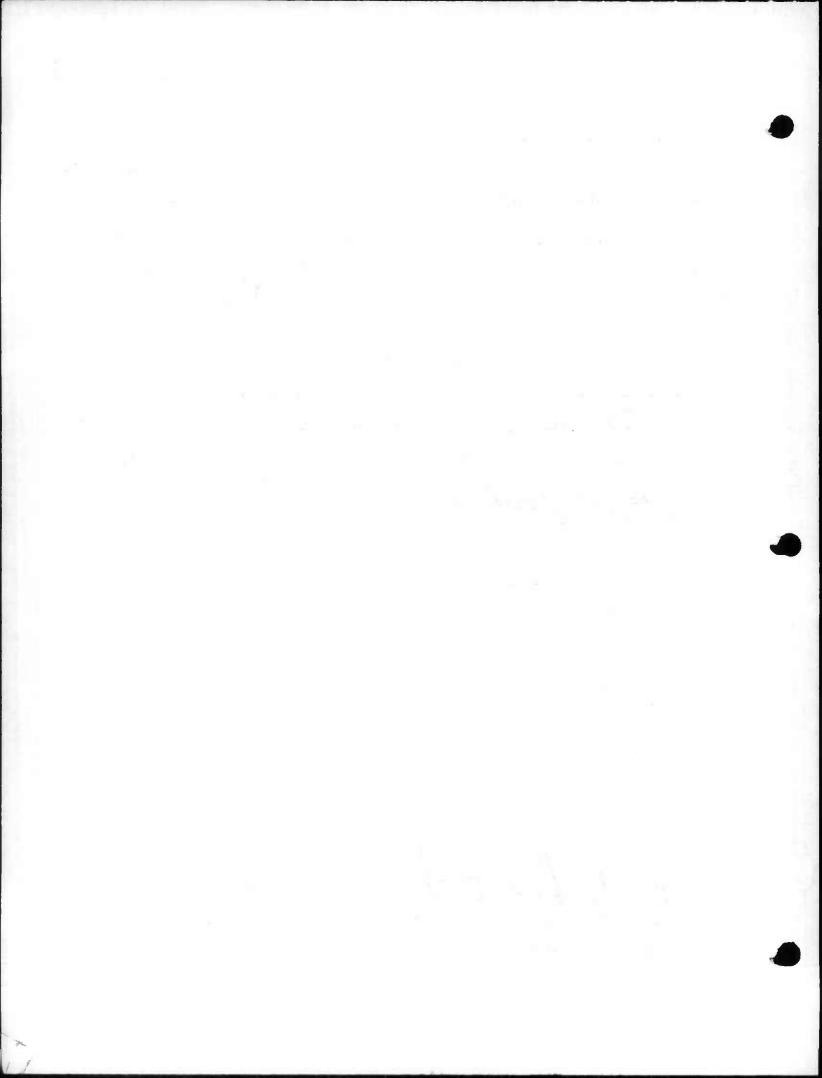


	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last	STATE OF MARY	CERTIF	FICATE OF	DEATH	2. DATE	REG. NO.		3. TIME OF DEATH
	Dorothy Lauderda	ale				3		93	YEAR
	4. SOCIAL SECURITY NUMBER 57809-7514	1 🗆 M 2 📉 F	E (In yrs. last birthday) 80 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Month	OF BIRTH Day, Year) 12/12		BIRTHPLACE (State or Foreign Country) Paris Virgini
œ	Bis. FACILITY NAME (If not institution, give	e street and number)		- 54	OR LOCATION OF D	EATH		1.0	Y OF DEATH
ECTOR	Doctors Hosp.			Lanham				Princ	e George's
DIR		m rince George		TY, TOWN OR LOCAL	e				10d. INSIDE CITY LIMITS? XXXXYES 2 NO
ERAL	3904 73rd.			1	20784				N OF WHAT COUNTRY?
BY FUNE	11. MARITAL STATUS 1 Never Married X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR		if yes, s	CENDENT OF HISPA pecify Cuban, Mexic s X X YWO Speci	an. Puerto F	7 (Specify Yes tican, etc.)		ted States 1. RACE — American Indian, Black, White, etc. Specify:White
ETED	15. DECEDENT'S ED (Specify only highest gra	de completed)	16a. DECEDENT'S	S USUAL OCCUPAT I work done during muse retired.)	ION nost of working		KINO OF BUS	INESS/INDUS	STRY
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)		one Opera			&P elecom	unicai	tions
COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N				210113
BE	Unknown S 19a. INFORMANT'S NAME (Type/Print)	trother				ie Gr			
5	James R. Lauder	dale			end Number or Rural Je. Hyatt				
	20a, METHOD OF DISPOSITION 1 (A Burial 2 Cremation 3 Re		0b. PLACE AND DATE	OF DISPOSITION (A		DATE			ty or Town, State
	4 Donation 5 Other (Specify)	A 1	emetery, crematory or Fort Linc	oln Ceme		3/8/9	93 Bre	ntwood	i, Maryland
	21. SIGNATURE OF FUNERAL SERVICE I	LICENSEE		ort Lincoln Cemetery 3/8/93 22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral					
_		1.0		Fort		Fune	ral Hor	me, In	nc.
	22 PART 100 In discussion	Tark		3401	Lincoln Bladensh	ourg l	Rd. Br	entwoo	od, Md. 20722
	23. PART i. Enter the diseases, or ahock, or heart failure iMMEDIATE CAUSE (Final disease or condition resulting in death)	a Chronic	each line.	not enter the m	Lincoln Bladensh	ourg l	Rd. Br	entwoo	od, Md. 20722
ERTIFICATION	immediate cause (Final disease or condition	a. Chronic DUE TO (OR AS C. Diabet	C Vasculi	3401 not enter the m .tis OF):	Lincoln Bladensh	ourg l	Rd. Br	entwoo	od, Md. 20722 tt, Approximate interval Between
ᅙᅵ	immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. Chronic DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS	each line. C Vasculi B A CONSEQUENCE C LES B A CONSEQUENCE C	3401 not enter the m tis OF):	Lincoln Bladensh ode of dying, su	ourg]	Rd. Br	entwo	od, Md. 20722 tt, Approximate interval Between
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CIAN: MEDICAL	Anock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	a. Chronic DUE TO (OR AS C. DUE TO (OR AS C. DUE TO (OR AS d. DUE TO (OR AS	each line. C Vasculi B A CONSEQUENCE OF B A CONSEQUENCE OF B A CONSEQUENCE OF B Dut not resulting	3401 not enter the m tis OF): OF):	Lincoln Bladensh ode of dying, su	ourg]	24a. WAS AN / PERFORI	entwo	Approximate interval Between Onset and Dead Onset a
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BALTIMORE, MARYLAND 21203-3146	SJCIAN: The law requires that the death certificate be executed with! nours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	ne medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 13146,	TO THE HIGHTAL OF ATTENDING PHYSICIAN; The law requires that the death certificate be executed within	TO THE PLACE CRECION: After this certificate has been signed by the attending physician and completely filled in by the face of white 72 hours are death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: Il Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR			CERTIF	ICAL	E UF	DEATH		REG. NO).			
	1. DECEDENT'S NAME (First, Middle, Last)							2.	DATE OF DEATN			3. TIME OF DEATN	
	AKIN NMN LITTL	F IR							EBRUARY	OAY 22	1993	10:51 A M	
	4. SOCIAL SECURITY NUMBER	5. SEX	6 AGE (In v	rs. last birthday)	IF UNDER	1 VEAD	IF UNDER 24 HR		DATE OF BIRTH	23,	V	PLACE (State or Foreign	
				YRS.	MONTHS	DAYS	HOURS MIN		(Month, Day, Year)		Countr	γ)	
- 1	241-20-5701	1 M 2 □ F	71	THS.					8-29-192			th Carolina	
	9a. FACILITY NAME (If not institution, give a	street and number)			9b. CITY	, TOWN	OR LOCATION OF	DEATN	•	9c. COUNTY OF DEATN			
5	DOCTORS COMMUNIT	Y HOSPITA	\L		LAN	MAHV				PRINCE GEORGE			
Ĕ	RESIDENCE OF DECEDENT										THERE CECKED		
m	10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN	OR LOCAT	TION					10d. INSIDE CITY LIMITS?	
DIRECTOR	MARYLAND PRINC	E GEORGE'	S		FORES	STVI	LLE					1 X YES 2 NO	
	10e. STREET AND NUMBER					10	. ZIP CODE			10g. CIT	IZEN OF V	VHAT COUNTRY?	
2	7420 MARLBORO PI	KE					2078	5		U	.S.A.		
FUNERAL	11. MARITAL STATUS	T 42 WAS DECEDEN	T EVEO IN II	C ADMED	142	WAS DEC			ORIGIN? (Specify Y			- American Indian,	
3	1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1				If yes, sp	ecify Cuban, Ma	klean, P	uarto Rican, atc.)	aa or No—	Black	k, White, etc.	
BY	3 K Widowed 4 Divorced	IF YES, GIVE W	AR OR DATE	S		1 TYES	2 TINO Sp	ecify:			Speci	"y: BLACK	
		<u> </u>							,				
回	15. DECEDENT'S EDU (Specify only highest grade		16	Give kind of life. Do NOT u	work done	CCUPATION MO	ON est of working		16b. KIND OF BI	JSINESS/IN	DUSTRY		
iu	Elementary/Secondary (0-12)	College (1-4 or 5 +											
ᅙᅵ	9th			MAINTE	NCE V	VORK	ER				FEDI	ERAL GOV'T	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S	NAME ((First, Middle, Maide	n Surname)			
	AKIN LITTLE, SR.						GEOF	GIA	ANNE BE	RITT			
BE	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRES:	S (Street a	and Number or Ru	rai Routi	e Number, City or To	wn, State, Zi	io Code)		
유	JULIUS LITTLE (BROTHER)					TIZ DRI					20748	
	20a. METHOD OF DISPOSITION 1 ☑ Buriel 2 ☑ Crymetion 3 ☐ Ram	noval from State	of	ther place)	,		metery, crematory	or		OCATION -	_		
	4 Donatton 6 D Other (Specify)		HA_	RMONY								ARYLAND	
	21. Sydhature of Funeral Service Li	CENSEE			22.	NAME A	SON &	FACILI	INS FUNI	ERAT. 1	HOME	TNC	
	() /a /B	1	/						EET, N.V		WDC	_	
	- Hay	1704	_							-		20011	
	23. PART I. Enter the diseases, or shock, or heart failure.	List only one cau	t caused tr	na death. Do	not anter	r the mo	de of dying,	nuch a	s cardiac or res	piratory as	rrest,	Approximata	
				1 1997/01.								: Interval Between	
- 1	IMMEDIATE CAUSE (Finel		and the same of th									Interval Between Onset and Death	
	disease or condition	CARDIA	and the same of th										
		CARDIA	C ARR		OF):								
_	disease or condition	CARDIA DUE TO	C ARR	EST	*								
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Pages 1, 2, 3 should

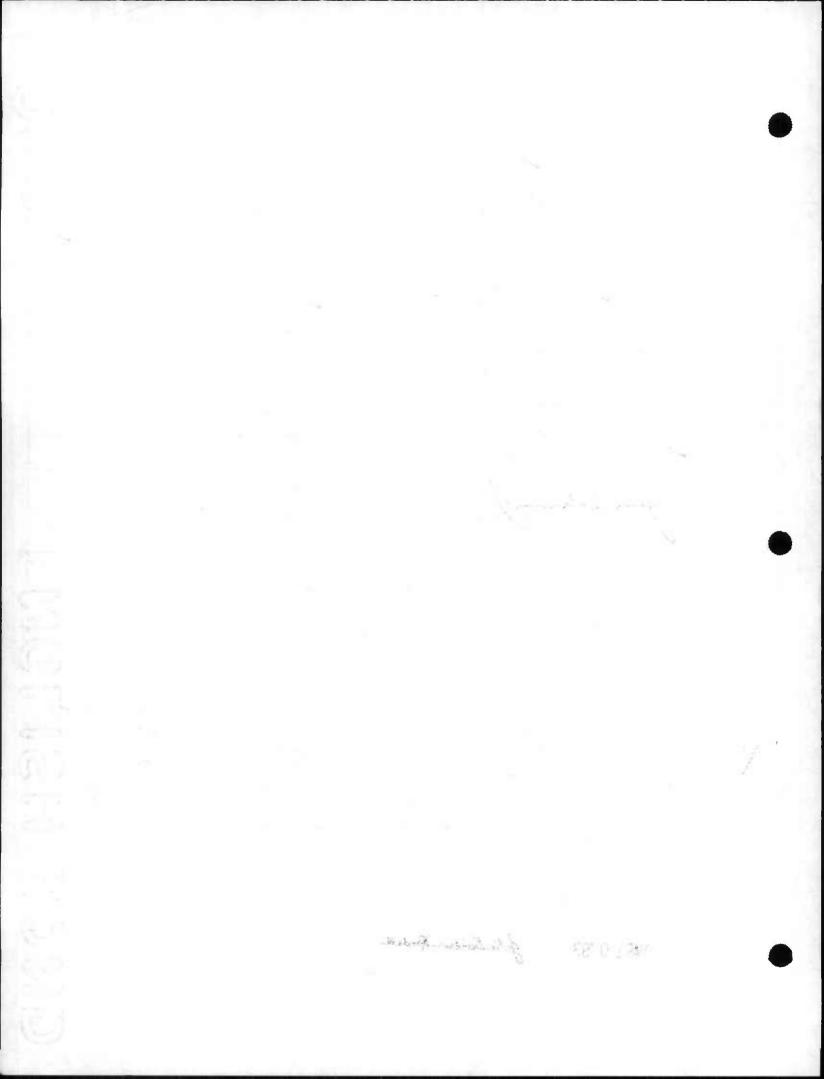
TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

68760, BALTIMORE, MARYLAND 21215-0020	TO THE PROSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE ELICEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	atic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be ex	TO THE FLAKERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be flied within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Day, Year)
WAR 1 0 '93

1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH		YEA		ME OF DEATH
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9e. FACILITY NAME (If not institution, give street	et end number)		9b. CITY, TOWN	OR LOCATION OF D	EATH		9c.	COUNTY		
32010 Perryhawk	kin Road		Prince	ss Ann	е			Some	erse	t
10e. STATE 10b. COUNTY			ITY, TOWN OR LOCA							INSIDE CITY LIMITS?
Maryland Some	erset		Princes	S Anne			100	CITIZEN	OF WHAT	YES 2 NO
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11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER FORCES? 1 YES	S 2 NO	Il yes, s	CENDENT OF HISPA pocify Cuban, Mexic	en, Puerto					nerican Indien, e, atc.
3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 🗆 YES	S 2 NO Speci	lly:				SpecMy: Whit	0
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(Specify only highest grade co		(Give kind o	of work done during m use ratired.)	ost of working	1.0					
Exementary/secondary (0-12)	Conege (1-4 OF 5+)	Г-	nmon			Λ.	mic		1170	
17. FATHER'S NAME (First, Middle, Last)		<u> </u>	rmer	18. MOTHER'S N	AME (First		ric		ure	
The state of the s	d lovesol	d								
Robley Raymond 199. INFORMANT'S NAME (Type/Print)	T FavileT		NG ADDRESS (Street	Elsi					(a)	
A STORE AND A STORE AS	C: 3.1					-5.1				
Mrs. Helen T. L		3201		hawkin		P:	_	nne		ryland
1 Burlei 2 - Cremation 3 - Remove	ral from State	of cemetary, cremato	TE OF DISPOSITION ory or other place)		DAT				or Town, S	
4 Donation 5 Other (Specify)		Olivet	Cemeter	ND ADDRESS OF F		9	den	, M:	aryl	and
21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE									
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	14	M00295		nan Fun				853		
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shock, or heert fellure. Lie	mplications that cous	ed the deeth. Do	Prin	cess A	nne.	Md	21			interval Between
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REG. NO.

2. DATE OF DEATH

1 - FOR STATE REGISTRAR

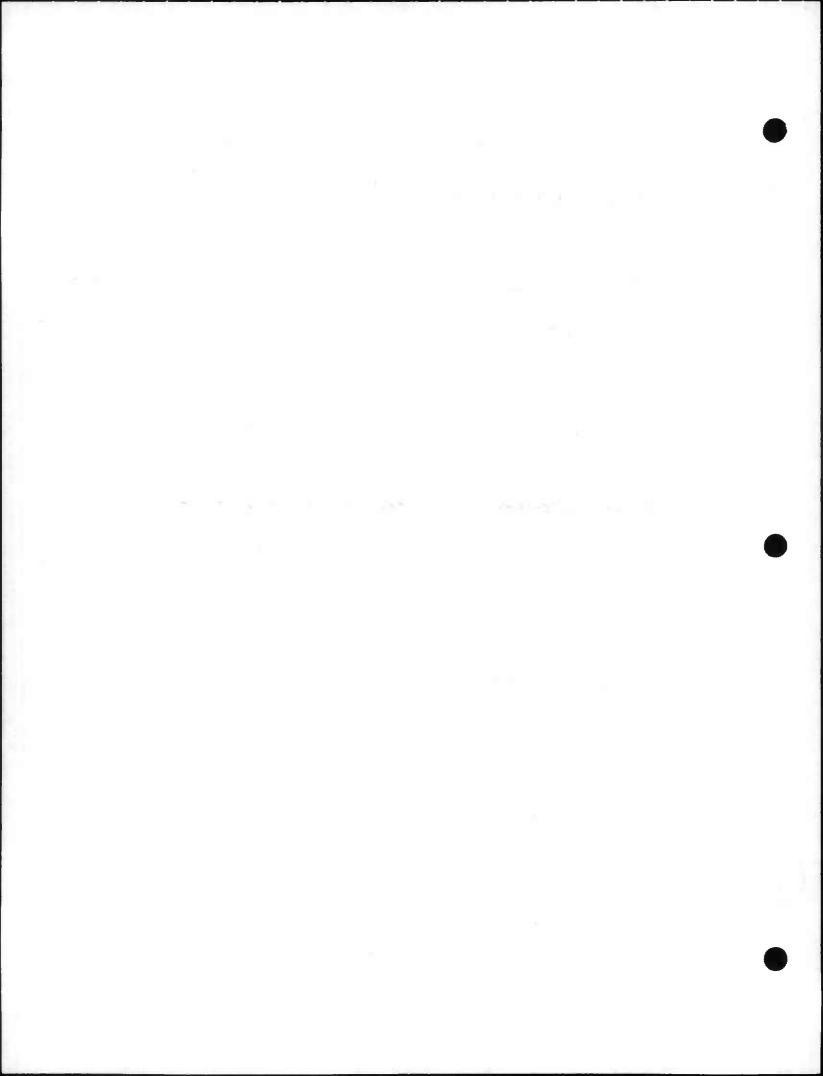
1. DECEDENT'S NAME (First, Middle, Last) WALTER K. LeCOMPTE

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DIVISION OF VITAL RECORDS, P.O. BOA 86/60,	OR ATTENDING PHYSICIAN: The law requires that the death certificate he executed within 24 ho
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3. TIME OF IDENTIFY M 393 9:50 PM WALTER K LECOMPIE 23 LeCompte 1616 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 214-01-2486 0371671919 MARYLAND 1 1 1 2 | F 74 YRS. permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DORCHESTER DIRECTOR DORCHESTER GENERAL HOSPITAL CAMBRIDGE RESIDENCE OF DECEDENT 10h COUNTY IRC CITY TOWN OR LOCATION 10d. INSIDE CITY DORCHESTER SECRETARY MARYLAND 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? for use as the burial-transit P.O. BOX 207 21664 U.S.A. ours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XYES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married IF YES, GIVE WAR OR DATES 1 TES 2 XNO Specify: BY WHITE/CAUC. 3 Widowed 4 Divorced WORLD WAR II COMPLETED 15. DECEDENT'S EDUCATION secily only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) detached 2+ MANAGER SHOE STORE 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) 2 76 LILIAN KOLB LEONARD LeCOMPTE BE notified 19a, INFORMANT'S NAME (Type/Print) (SPOUSE) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 LeCOMPTÉ P.O. JANE 207, SECRETARY, MD. 21664 D. BOX 2 20e. METHOD OF DISPOSITION
1 December 1 December 2 December 2 December 3 Dece 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must 1 Surial 2 Cremation 3 L 4 Donation 5 Other (Specify) funeral director, VETERANSCEMEASTSHORE3/19 HURLOCK, MD. 21. SIGNATURE OF FUHERAL SERVICE LICENSEE medicel examiner 22. NAME AND ADDRESS OF FACILITY CURRAN FUNERAL HOME 308 HIGH ST., CAMBRIDGE, MD. 21613 n and completely filled in by the to burial, cremation, or removal. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory streat, shock, or heart failure. List only one cause on each line 23. PART J. Enter the diseas Approximate m. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final Pancreatic CA with liver mets
CA WILLIAM WITH THE THE CONTROL OF T the disesse or condition Zuly event, resulting in death) traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): the attending physician Mental Hygiene prior tr cause. Enter UNDERLYING CAUSE (Disease or Injury Injury, or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS and AVAILABLE PRIOR TO shows any DDW COMPLETION OF CAUSE signed Health a 1 YES 2 NO 1 YES 2 NO t. of has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate f HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 6 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked, 28d. DESCRIBE NOW INJURY OCCURED with 1 1 Natural 5 Pending Investigation 1 YES 2 NO BY After I death 2 Accident DIRECTOR: At hours after de ltem 28 is r 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide TO THE FUNEFAL DIRECT
IN THE WITH 72 hours at 29s. CERTIFIER
(Check only

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE wout 7 3 7227 16152 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Cambridge AM ALLY 5037Byrn Street 31. DATE FILED (Morith, Day, Year) 93 Julia Daydson-Randall DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



YEAR

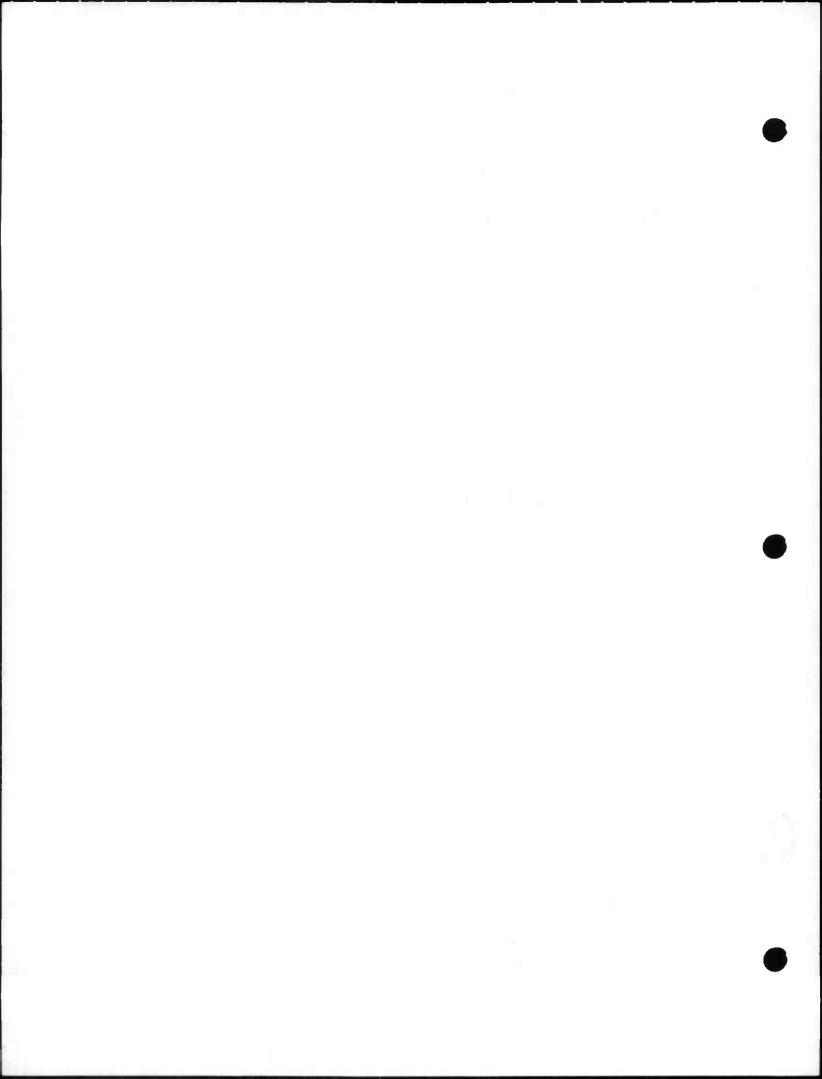
3. TIME OF DEATH

10:00 AM

2. DATE OF DEATH DAY MONTH DAY 1993

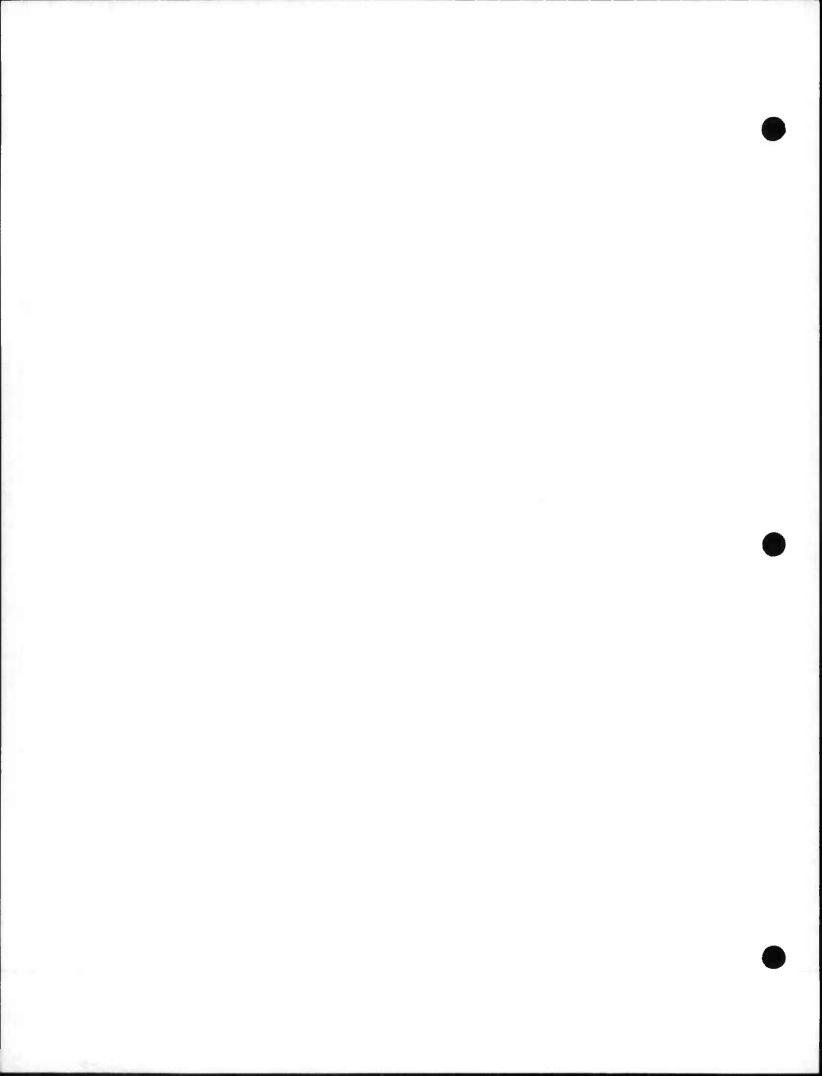
Joseph Michael Madden

		1.70 02 2500		1 🕅 M 2 🗆 F		rs. last birthday) O YRS.	MONTHS	1 YEAR DAYS	HOURS 2	MITTE.	(Month, D	wy, Year)		Country)	ACE (State or Foreign
pino		178-03-3590				8 YRS.	96 CITY	TOWN	OR LOCATIO			14,1		Y OF DEAT	ylvania
3 should	E E	205 Cedar I		,					Rockvi					ontgo	
1, 2,	5	RESIDENCE OF DEC					-								
Page	DIRECTOR	Maryland	10b. COUNT	Montgome:	rу	10c. C	TY, TOWN (тюн Rockvi	lle					ILIMITS?
il.	A	10e. STREET AND NUMBER	0					-10	H. ZIP CODE				10g. CITIZI		T COUNTRY?
h. ansit p	띮	205 Cedar I	ane						20	851			Unit	ed St	ates
BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physician. by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages moval. ical examiner must be notified at once.	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 3 Divo		12. WAS DECEDED FORCES? IF YES, GIVE YOU WILLIAM	YES :	ON S		f yes, or	CENDENT OF pecify Cuban S 2X NO	, Mexican, F	ORIGIN? (Puerto Rica	Specify Yes in, etc.)	or No- 1	4. RACE Black, W Specify: Whit	American Indian, thite, etc.
215 aften Se as			EDENT'S EDU y highest grade		10	e. DECEDENT	S USUAL O	CCUPATI	ION ost of working	7	16b. KI	ND OF BUS	SINESS/INDU	STRY	
MARYLAND 212: retained by the hospital or att 5 should be detached for use notified at once.	COMPLETED	Elementary/Secondary (6	1-12)	College (1-4 or 5		Accoun						Cons	truct	ion	
AN the hos detach	8	17, FATHER'S NAME (First, M	liddle, Last)						18. MOTH	ER'S NAME	(First, Mid	de, Malden	Sumame)		
MARYLAND retained by the hospit should be detached notified at once.	BE C	Michae	el Made	den						Mai	rgare	et Mu	rphy		
AR ained shouk	원 일	19a. INFORMANT'S NAME (Type/Print)			19b. MAILIN	G ADDRESS	(Street	and Number o	or Rural Rou	te Number,	City or Town	n, Stata, Zip C	(ode)	
D 20 50 00 00 00 00 00 00 00 00 00 00 00 00	=	Jean W. Ma	adden			205 C	edar	Lan	ne, Ro	ckvil	lle,	Mary	land	2085	1
ORE i may tor, pa		20e. METHOD OF DISPOSIT 1 □ Burlel ②XXCrematic	on 3 🗆 Rem	oval from State	cemere	ACE AND DATE	Other Discel						CATION - CI		
M direct		4 Donation 5 Other 21. SIGNATURE OF FUNERA		YEMPER .	Mon	tgomer									yland y Funeral
BALTIMORE, MAR's thours after death. Page 6 may be retained filled in by the funeral director, page 5 should on, or removal.		Mich	ele C	9. Ku	la M	00348	He	ome/		ille,	, Inc	., 3	00 W.	Mont	gomery Ave
B, n by the removal.		23. PART i, Enter the d	iseases, Dr	complications the	t caused th	e death. Do									Approximate
		iMMEDIATE CAUSE (Fit disease or condition resulting in death)		a. Court	record to a train	TUV Ø ONSEQUENCE (A.	RI	m7	EA	u	uni	٤		interval Between Onset and Death
RECORDS, P.O. BOX 68760, requires that the death certificate be executed within 24 neen signed by the attending physician and completely filler, of Health and Mernal Hygiene prior to burial, cremation, shows any injury, or other traumatic event, the	CERTIFICATION	Sequentially list condit if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inju- that initiated events resulting in death) LAS	diate iNG iry	oue to	(OR AS A CC	C C/ ONSEQUENCE (OF):	NO.	re ye	OPA	THE	3			Sylus -
ORDS, that the de de by the a th and Merrit and Merrit any injury		PART II. Other aignifice	ent condition	s contributing to	death but	not resulting	in the ur	derlyin	ng ceuse gi	iven in Pa	rt i. 24	le. WAS AN			ERE AUTOPSY FINDINGS
OF oned that afth a	EDICAL						-				_ 1	YES 2	□Хио		OMPLETION OF CAUSE F DEATH?
AL RECORE e law requires that th has been signed by t Dept. of Health and	Σ										-			1	YES 2 NO
	CIAN	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL					26. P	LACE OF DE	ATH (Check	only one)				
		1 YES 2 NO		HOSPITAL:	☐ ER/Outpatie	ent 3 🗆 DOA	4 Nur		ne 5 🔽 Res	sidence 6	Other (S	(pecify)			
OF VI	PHYS	27. MANNER OF DEATH 1 X Natural 5	Pending	26a. DATE Of (Month, I	F INJURY Day, Year)	28b. TI	ME OF	W	JURY AT ORK?	_	d. DESCR	IBE HOW I	NJURY OCCU	IRED	
ON OF DING PHYS After this clearly with	B	2 Accident	Investigation	28a DI ACE I	NE IN HIBY	At home, farm,	-10		YES 2						
8	TED	3 Suicide 6 4 Homicide	Could not be determined	building	etc. (Specify)	At nome, term,	street, fact	огу, отк	ce	21	City or	ON (Street a fown, State)	and Number o	r Hurai Houl	e Number,
	COMPLET	(31.551.511)		ICIAN: To the best of											nd manner as stated.
# # # # # # # # # # # # # # # # # # #	BE C	296 SHONATURE AND TYPLE	OF CERTIFIE	-	0				29c. LICE	NSE NUMBE	R		29d. DATE	SIGNED (M	onth, Day, Yber)
TO THE HOSE TO SHE FLAKEN BE SHED WITHIN THE PROPERTY.	TO B	30. NAME AND ADDRESS O	F PERSON WH	O COMPLETEO CAL	SE OF DEATH	(ITEM 22) Typ	e, Print)		INO))	64		Ma	rch]	5. 1993
X		Joel A. Rei	iskin,	M.D., 5	W. E	dmonst	on D	rive	# 60	2 Roc	ckvi]	lle,	Mary1	and 2	0852
		MAR 16	. 93	Gulia	Davidson	Mandel	2								



	DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 2121; BALT
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	FOR 1 - STATE REGISTRAR	STATE OF MARYI	AND / DEPAR CERTIF	TMENT OF	HEALTH AND	MENTAL HYG					
	1. DECEDENT'S NAME (First, Middle, Last))				2. DATE OF DEAT	Н		3. TIME OF DEATH		
	DORIS CHRISTINE	IS CHRISTINE MILLAR					MARCH 14, 1993 5:3				
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	i. 1	6. BIRTH	PLACE (State or Foreign		
	147-09-5174	1 ☐ M 2 💢 F	1 M 2 F 83 YRS. MONTHS DAYS HOURS MIN.			(Month, Day, Year) Dec. 25,1909 England					
#	Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF										
O. H	7409 OAKCREST LANE CLARKSVILLE HOWARD										
ᇈ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT		1 22 22								
DIRECTOR		ward Clarks			1171			10d. INSIDE CITY LIMITS?			
1	10e. STREET AND NUMBER		f. ZIP CODE	1 TYES 2							
RA						10g. CITIZEN OF WHAT COUNTRY? -1826 United States					
FUNERAL	11. MARITAL STATUS					NIC ORIGIN? (Specif			4. RACE — American Indian,		
	1 Never Married 2 Married	FORCES? 1 YES		If yes, s	nn, Puerto Rican, etc		Black	Black, White, etc. Specify:			
ВУ	3XXWidowed 4 Divorced	XXWIdowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 XNO					оросну.				
Œ	15. DECEDENT'S EDI (Specify only highest gred	UCATION le completed)	16a. DECEDENT'S	USUAL OCCUPATI	ON ost of working	White					
"	Elementary/Secondary (0-12)	College (1-4 or 5+)	iffe. Do NOT use retired.)								
COMPLET		2	Secr	etary			I Found	latio	n		
	17. FATHER'S NAME (First, Middle, Last)	1.2.				ME (First, Middle, Ma					
B	Leonard Ma 19a. INFORMANT'S NAME (Type/Print)	rknam				a Amelia					
2	Martha L. Milla	*				Route Number, City of Clarksvi			20-1026		
								_			
- 1	20e. METHOD OF DISPOSITION 1 Burlel 242 Cremation 3 Rer 4 Donation 5 Other (Specify)	moval from State C9	b. PLACE AND DATE Of metery, crematory or or MONTGOMER	ther place	torium	The I			aryland		
	21. SIGNATURE OF FUNERAL SERVICE L		Tonegomen						rey Funeral		
	n.	2-1/1×		Home/	Rockvill	e, Inc.,	300 W.	umpn Mon	tgomery Ave		
-	Michele	1 : IIUXIII	400348	Rockv	ille, Ma:	ryland 2	20850-2	2805	J 1		
	23. PART i. Enter the diseases, or ehock, or heert feliure.	complications that ceuse List only one ceuse on a	d the death. Do n	ot enter the me	de of dying, suc	h as cardiac or n	espiratory an	reat,	Approximata interval Between		
	IMMEDIATE CAUSE (Final										
	disease or condition resulting in death) Stroke										
	DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentially list conditions, Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF):										
'AT	If any, leading to immediate cause. Enter UNDERLYING	,	etes Mell								
E	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	7):					· · · · · · · · · · · · · · · · · · ·		
눈	resulting in death) LAST	4									
	DART II Other cignificant and disc	PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
SAL	PART II. Other alignificant conditio	ins contributing to deeth i	out not resulting i	n the underlyin	g ceuse given in		S AN AUTOPSY REORMED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO		
MEDIC						1 _ YE	S 2 (X NO		OF DEATH?		
						- 1			1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL										
S	EXAMINER? 1 YES 2XXNO	HOSPITAL:	S.S	OTHER:	LACE OF DEATH (Ch						
Ϋ́ I	27. MANNER OF DEATH	1 Inpatient 2 ER/Out 28s. DATE OF INJURY	28b. TIM		NO SYLXResidence	6 Other (Specify) 28d. DESCRIBE HO		CHRED			
	Natural 5 Pending	(Month, Day, Year)		URY W	PRK?	aud. DEJONIBE N	on maoni oca	CONED			
BY	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJUR	r — At home, farm, a			28f. LOCATION (St	met and Number	or Bural Re	or Rural Bouta Mumber		
冒	4 Homicide 8 Could not be determined	building, etc. (Spe	cify)	200		City or Town, S	Tato)				
COMPLETED	29a. CERTIFIER 1XXCERTIFYING PHYS	SICIAN: To the best of my know	dedos desth	ed at the star 1 d 2	and alcon 1 1 1	44.4					
MP		ER: On the basic of examination							and manner as stated		
	29b. SIGNATURE AND TITLE OF CERTIFIE										
BE	Signal One And Title OF CENTIFE	I.R.			29c. LICENSE NUI				(Month, Day, Year)		
5	30. NAME AND ADDRESS OF FERSON WI	HO COMPLETED CAUSE OF DI	ATH (ITEM 27) (Type	Print)	MD252	10	MA	RCH	15, 1993		
	J. ELZIS SEALS,	M.D. 3460 H	ELLICOTT		DRIVE, E	LLICOTT (CITY, M	D 2	1043		
	31. DATE FILED (Month, Day, Year) MAR 16 93	32. MEGISTRAB'S SIGN	ATURE and BL								



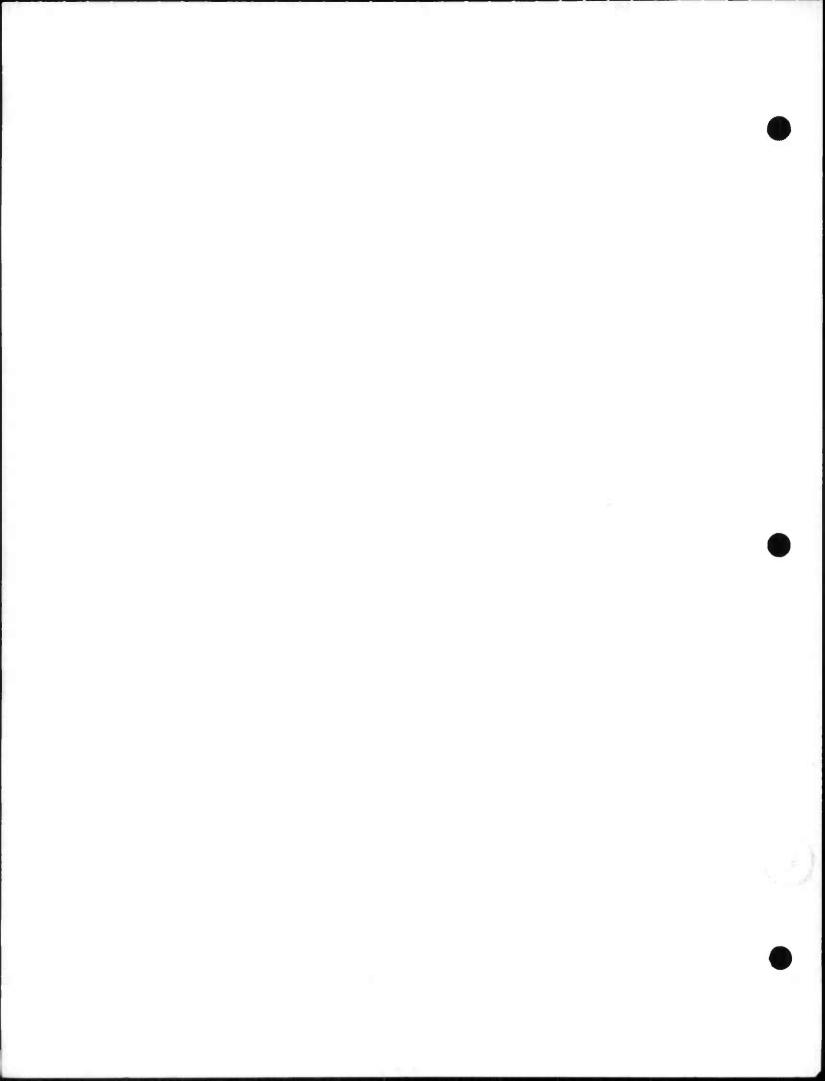
	STATE OF MARYLAND / DEPARTMENT OF HEALI		IYGIENE
REGISTRAR	CERTIFICATE OF DE	ATH F	REG. NO.

	* REGISTRAR				ERTIF	ILAIR	- ()-		н		REG. NO			
ı	1. DECEDENT'S NAME (First, I	Middle, Last)							-		OF DEATH		-	3. TIME OF DEATH
		Sh	irlee S.	Murray						MONT			YEAR Q 3	6:20 A
	4. SOCIAL SECURITY NUMBER	R	5. SEX	6. AGE (In yrs. I	last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTN	0		NPLACE (State or Foreign
	390-14-0113		1 🗌 M 2 💢 🤾 F	69	YRS.	MONTHS	DAYS	HOURS	MIN.		h 28,1	023	Coun	consin
	Sa. FACILITY NAME (If not inst	titution, give s	treet and number)		_	9b. CITY	, TOWN O	R LOCATIO			11 20,1		INTY OF	
8	23501 Pocahontas Drive					GAITHERSBURG MONTGOMER								
DIRECTOR	RESIDENCE OF DECEDENT					101110111111								
뿚		10b. COUNTY			10c, CIT	Y, TOWN								10d. INSIDE CITY LIMITS?
	Maryland	WO	rcester			В	erli	n						1 TES 2 1 NO
\¥	10e. STREET AND NUMBER				10f. ZIP CODE									WHAT COUNTRY?
FUNERAL	74 Club House Drive				21811								ted	States
5	11. MARITAL STATUS 1 Never Married 2 Married FORCES?			EVER IN U.S. ARMED X YES 2 NO		13. WAS DECENDENT OF NISPANII If yes, specify Cuban, Mexican,			IIC ORIGIN? (Specify Yes or No-		14. RACE — American Indian, Black, White, alc.			
B		3 🔀 Widowed 4 Divorced IF YES, GIVE WAI			R OR DATES			1 YES 2 NO Specify:					Specify:	
	15. DECEDENT'S EDUCATION				16a. DECEDENT'S USUAL OCCUPATION					1			White	
COMPLETED	(Specify only i	highest grade	completed) College (1-4 or 5 +		(Give kind of work done during most of working life. Do NOT use retired.)			g	16b. KIND OF BUSINE			IESS/INDUSTRY		
딥		121	5+	"	Rea	ltor					Real E	stat	e	
O	17. FATHER'S NAME (First, Mid	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NAM	ME (First I	Aiddle, Maiden	Sumamel		
	F1	oyd S	yron							Luth		00110110)		
BE (19a. INFORMANT'S NAME (Typ		-	1	19b. MAILING	ADDRESS	S (Street at	nd Number	or Rural R	loute Numl	oer, City or Tow	n. State. Zi	o Code)	
5	Annette Mur	ray												ID 20882
	20a, METNOD OF DISPOSITIO		G-	20b. PLACI	E AND DATE	OF DISPOS	ITION (Na							own, State
		MXBuriel 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) ☐ Gate of H				ther blace)				-				ng, Maryland
1	21. SIGNATURE OF FUNERAL	SERVICE LI	ENSEE Y	6		22.	NAME AN	D ADORES	S OF FAC	HUTY R				rey Funeral
1	Mil	1.15	1 Stay	110	M0034	e H	ome/	Rock	vill	e, I	nc., 3	00 W	. Mc	ntgomery Ave
-	23. PART i. Enter the dis	ACOUNT OF C	complications the	CCCC		11		ille				850-		
- 8	snock, or nee	ert fallure.	List only one cau	se on each ilr	ne.	iot enter	trie mot	ae or ayı	ng, sucn	ss cerc	lec or respi	ratory si	rest,	Approximata interval Between
	immediate Cause (Fine) disease or condition resulting in death) DIF TO (OR AS A CONSPONENCE OF)													
	resulting in death)		OUE TO	OR AS A CONS	FOURNCE O	57	20	DID	as	لاسرا	ج کھ	454	حم	8
_	BUE TO (UN AS A CONSEQUENCE OF):													
ē	Sequentially list conditions, If any, leading to immediate b. OUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	cause. Enter UNDERLYIN	IG	c.											
띨	that initisted events		CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF):											
띮	resulting in death) LAST											i		
		ı,	d											
	PART II. Other significant		d	death but not	resulting	In the un	declulos		iven in f	Don't I			T	
CAL C	PART II. Other significant		d	death but not	reaulting	In tha un	darlying	cause g	iven in F	Part I.	24a. WAS AN PERFOR		248	D. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
CAL	PART II. Other significant		d	death but not	reaulting	in tha un	darlying	Cause g	iven in F	Part I.		MED?	248	
MEDICAL	PART II. Other significant		d	death but npt	reaulting	in tha un	darlying	cause g	iven in F	Part I.	PERFOR	MED?	248	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL		t condition	d	death but not	reaulting	in tha un				_	PERFOR 1 VES 2 LICAC	MED?	248	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO EXAMINER? **EXAMINER OF DEATH 1 Netural 5 Periods **EXAMINER OF DEATH 1 Netural 5 Per	t condition	s contributing to	ER/Outpetlant	3 DOA	OTHEF	26. PL	ACE OF OE	EATH (Che	ck only on	PERFOR 1 VES 2 LICAL 0 1	MED?		AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO EXAMINER? XXYES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pt 2 Accident Im	MEDICAL anding westigation	HOSPITAL: 1 Inputiant 2 28a. DATE OF (Month), Do	ER/Outpetlant INJURY oy, Year)	3 DOA 28b. TIM	OTHEF 4 Num E OF URY M	26. PL/street PL	ACE OF OB ACE OF OB PRINT AT RK? ES 2	EATH (Che	ck only on 5 Other 28d. OES	PERFOR	MED?	CURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO EXAMINER? XXVES 2 ONO 27. MANNER OF DEATH 1 Natural 5 Pa 2 Accident Im 3 Suicide 8 Ca	t condition	HOSPITAL: 1 Inpettent 2 28a. DATE OF (Month, Di	ER/Outpetlant	3 DOA 28b. TIM	OTHEF 4 Num E OF URY M	26. PL/street PL	ACE OF OB ACE OF OB PRINT AT RK? ES 2	EATH (Che	ck only on 5 Other 28d. OES	PERFOR 1 VES 2 LICATO (Specify)	MED?	CURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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BALTIMORE, MARYLAND 21215-0020	er death. Page 6 may be retained by the hospital or attanding physician. The funeral director, page 5 should be detached for use as the bunal-transit permit. Pages val.	i examiner must be notified at once.	
CopyISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE TOWNER PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defacted for use as the burial-transit permit. Page be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO THE PARTY OF THE PROPERTY O

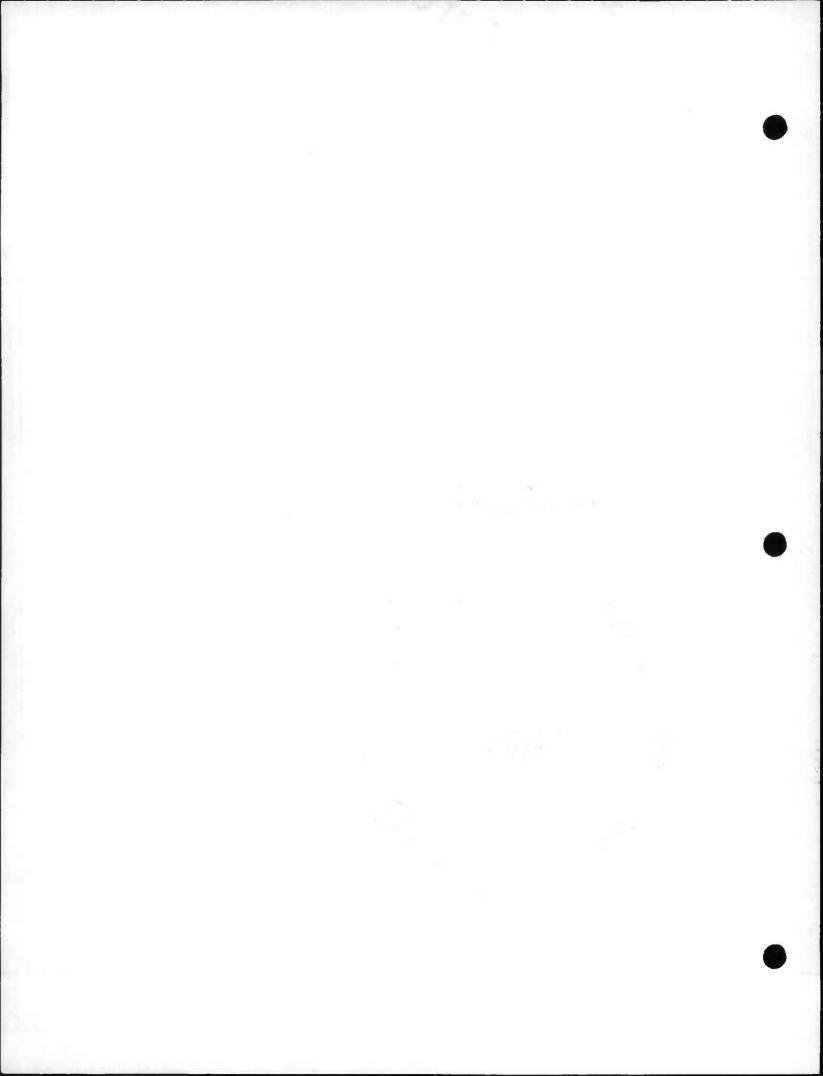
	FOR 1 - STATE REGISTRAR	STATE OF MAR	RYLAND	/ DEPAR	TMENT	OF H	EALTH AND	MENT	AL HYGIEN					
į	1. DECEDENT'S NAME (First, Middle, Last)						DEMIN	2 DAT	E OF DEATH			3. TIME OF DEATH		
,	Bertha			McKei	th			MON	TH O	, 199	3 YEAR	6:50 P M		
	4. SOCIAL SECURITY NUMBER 479-09-5850	S. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH MONTHS DAYS HOURS MIN. (Month, Day Year May 13, 1								s. BIRTHPLACE (State or Foreign Country) England				
H.	9a. FACILITY NAME (If not institution, give s Bethesda Nursing	& Retirement Ctn. She city, Town or Location of Death Only Chase Oc. COUNTY OF DEATH Ontgom								EATH				
5	RESIDENCE OF DECEDENT		Hoffegome											
DIRECTOR	10e. STATE 10b. COUNT	77 14								10d. INSIDE CITY LIMITS? 1 A YES 2 NO				
FUNERAL	100. STREET AND NUMBER 4201 Butterworth	worth Place, N.W. 20016 USA								YHAT COUNTRY?				
В	11_ MARITAL STATUS 1	12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR O	YES 2	ARMED	1 1	f yes, sp	ENDENT OF HISPAI ectly Cuben, Mexica 2 NO Specifi	en, Puerto	IN? (Specify Yes	or No—	14. RACE Black Speci	— American Indian, t, White, atc.		
COMPLETED	15. DECEDENT'S EDU (Specily only highest grade Elementary/Secondary (0-12)		- 1	DECEDENT'S (Give kind of v	work done i	CCUPATIO	DN st of working	16	b. KIND OF BU	SINESS/IN	DUSTRY			
A I		2	E	xecut	ive S	Secr	etary		Gener	al M	otors	5		
	17. FATHER'S NAME (First, Middle, Last) George Robert Me	cKeith					18. MOTHER'S NA		Middle, Melden					
) BE	19a, INFORMANT'S NAME (Type/Print)		T	19b. MAILING	ADDRESS	(Street a	nd Number or Rural				D Code)			
임	Donald C. Gilli	es					t.,NW, W					0005		
	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State		E AND DATE (TE 20c. LO	exan				
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE					o address of FA	1			4124	, 111		
	* micho!	2. Me	lao	~	51	.30	Wisconsi	n Av	e,NW,W	ashi		n,DC 20016		
	23. PART I. Enter the diseases, or enock, or heert failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Liet only one ceuse of the control one ceuse of the ceuse	on eech II:	ne.				h aa ce	rdiec or reep	ratory er	reet,	Approximate Interval Between Onset and Death		
CERTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. OUE TO (OR) C. DUE TO (OR)												
PHYSICIAN: MEDICAL	PART II. Other significent condition	s contributing to deep	th but not	reaulting l	n the un	derlying	ceuse given in	Pert I.	24a. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINOINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
ž												1 YES 2 NO		
₹	25. WAS CASE REFERRED TO MEDICAL EXAMINER?						ACE OF DEATH (Ch	eck only o	nne)	-				
Š	1 TYES 2 NO	HOSPITAL: 1 Inpatient 2 ER/	Outpatlant	3 🗆 DOA	OTHER 4 E Num	i: ing Hom	5 🗆 Rasidenca	e 🗆 Oth	er (Specify)					
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJU (Month, Day, Ye	RY ar)	26b. TIM	E OF URY M	28c. INJI WO	RK?	28d. DE	SCRIBE HOW I	NJURY OC	CURED			
ED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	Investigation 6 Could not be 26s. PLACE OF INJURY — At home, tarm, street, factory, office building, etc. (Specify) 26s. PLACE OF INJURY — At home, tarm, street, factory, office 26s. LOCATION (Street and Number or Rural Route Number,								oute Number,				
COMPLETED		CIAN: To the beat of my k												
ខ្ល	one) 2 MEDICAL EXAMINE		urtion and/o	r Investigatio	n, In my o	pinion, d	eath occured at the	time, dat	a and place, an	d due to th	e cause(a	and manner as stated.		
	296. SIGNATURE AND TITLE OF CERTIFIES	1100	12.	121	,,,		D 16	WBER /	9	29d. DAT	E SIGNEO	(Month, Day, Year)		
٤	30. NAME AND ADDRESS OF PERSON WH										71			
	Stuart E. Ross			sconsi	n Av	e,N	V,Washin	gton	,DC 20	016				
	MAD 1 4 100	32. REGISTRAR'S S		D \$ 00										



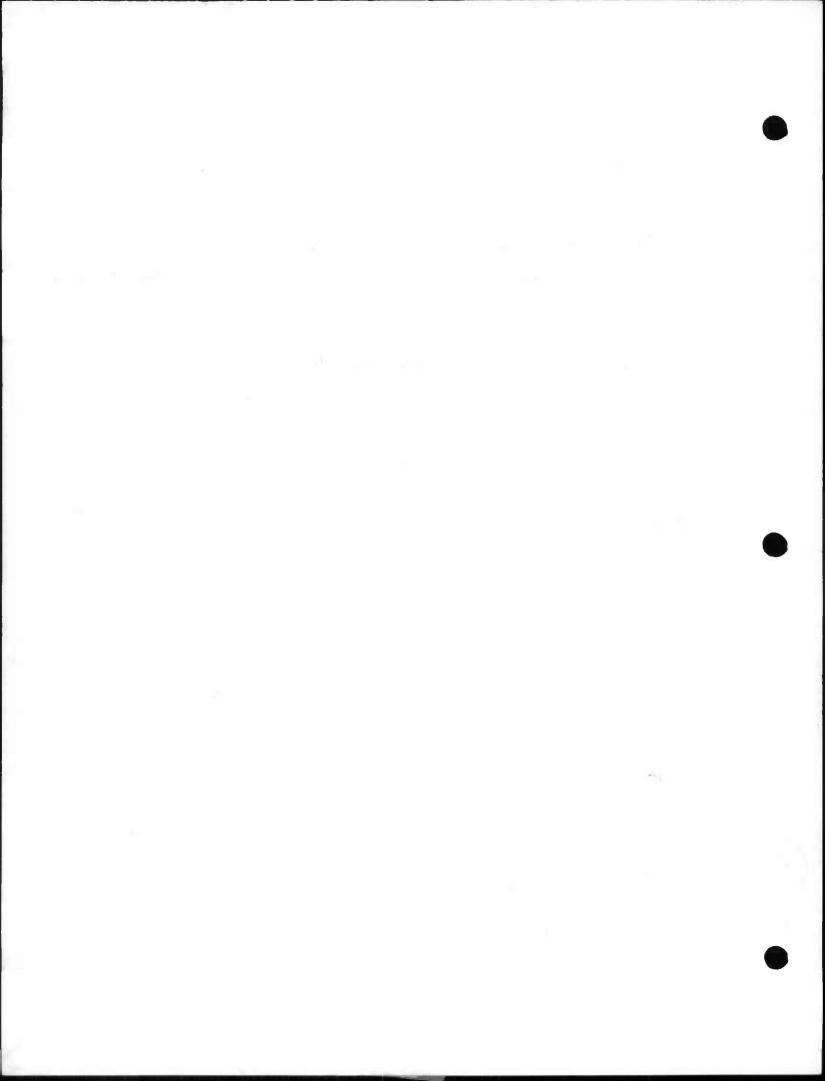
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	FOR STATE REGISTRAR	STATE OF MA	RYLAND /	DEPARTME	NT OF I	HEALTH AND	MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, La EUGENI	A ELIZABETH					MONT	OF DEATH	AV	YEAR 3.	8:20
	4. SOCIAL SECURITY NUMBER 578-60-9889	5. SEX 6.	AGE (In yrs. lest	yrs. HONT		IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mon MA	OF BIRTH th, Day, Year) Y 7 19	- 1	L BIRTHPL Country)	ACE (State or Foreign
OR BO	90. FACILITY NAME (If not institution, gi		<u>NTE</u> R	9b. (OR LOCATION OF D ETHESDA	EATH		9c. COUNT		OMERY
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COU MARYLAND MO	NTY NTGOMERY		10c. CITY, TOV	N OR LOCA	-71				1135	d. INSIDE CITY LIMITS? YES 2 X NO
RAL	100. STREET AND NUMBER 1000 DALEVIEW	DRIVE				f. ZIP CODE					T COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1	YES 2 N	MED	If yes, sp	20901 CENDENT OF HISPA Hecity Cuban, Mexico 2X NO Special	en, Puerto	N? (Specify Yer Rican, etc.)		4. RACE — Black, W Specify:	TATES American Indian, rhite, etc. WHITE
LETED	15. DECEDENT'S E (Specify only highest gr Elementary/Secondary (0-12)		16a. DEC (Gh life.	CEDENT'S USUA re kind of work do Do NOT use retin	. OCCUPATE ine during mod.)	ON ost of working	160	b. KIND OF BU	SINESS/INDU		WILLIE
COMP	17. FATHER'S NAME (First, Middle, Last)	4		HOMEM	AKER	18. MOTHER'S NA	ME /Elest	Afiririta Afairian	Sumama)		
BE C	EUGENE MOCK					LORETT			,		
TO B	19a. INFORMANT'S NAME (Type/Print)		19b	MAILING ADDF	ESS (Street	and Number or Rural				iode)	
	EUGENE P. MCELW	EE	_			L_DRIVE.					MD 2081
	1 \(\) Burial 2 \(\) Cremation 3 \(\) R 4 \(\) Donation 5 \(\) Other (Specify)	emoval from State		nd DATE OF DIS		al Cem.	3/		cation - ci		
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	lson		Josep	no ADDRESS OF FA h Gawler Wisconsi	S S	ons, I	nc.		
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. CARDIAC ARRYTHMIA DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									Interval Betwood
MEDICAL	PART II. Other algorificant condit	d.	eath but not re	esulting in the	underlyin	g cause given in	Part I.	24s. WAS AN PERFOR 1 (X) YES 2	AMED?	AM CC OF	RE AUTOPSY FIND AILABLE PRIOR TO MPLETION OF CAU DEATH? YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	P/Outration 2	OTH	IER:	LACE OF DEATH (C)					
BY PHY	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF IN. (Month, Day,	JURY	28b. TIME OF INJURY	28c. IN.	NURY AT ORK? YES 2 NO		SCRIBE HOW I	NJURY OCCU	RED	-
-	2 Desirable — 286, PLACE OF INJURY — At home farm street factory office 261 I OCATION (Street and Number or Dural Pour								Rural Rout	Number,	
TO BE COMPLETED		YSICIAN: To the best of my INER: On the basis of exen									ed manner es state
BE C	296. SIGNATURE AND TITLE OF CERTI	700.	и	1 ,		29c. LICENSE NU	MBER		29d. DATE	SIGNED (M	orith, Day, Year)
70	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CALLER	OF DEATH (ITEM	27) (Turns Ori-1		7004 (77 A T	DIGIT	3 13	- 13
	NEIL M. SULLIV			e ≼rj(nype, Pπint)		NATIONA BETHESD				CENT	ER
	31. DATE FILED (Month, Day, Year) MAR 16 93	32. BEGISTRAM		Indell		DETHEOD	M LID	20009	-0000		
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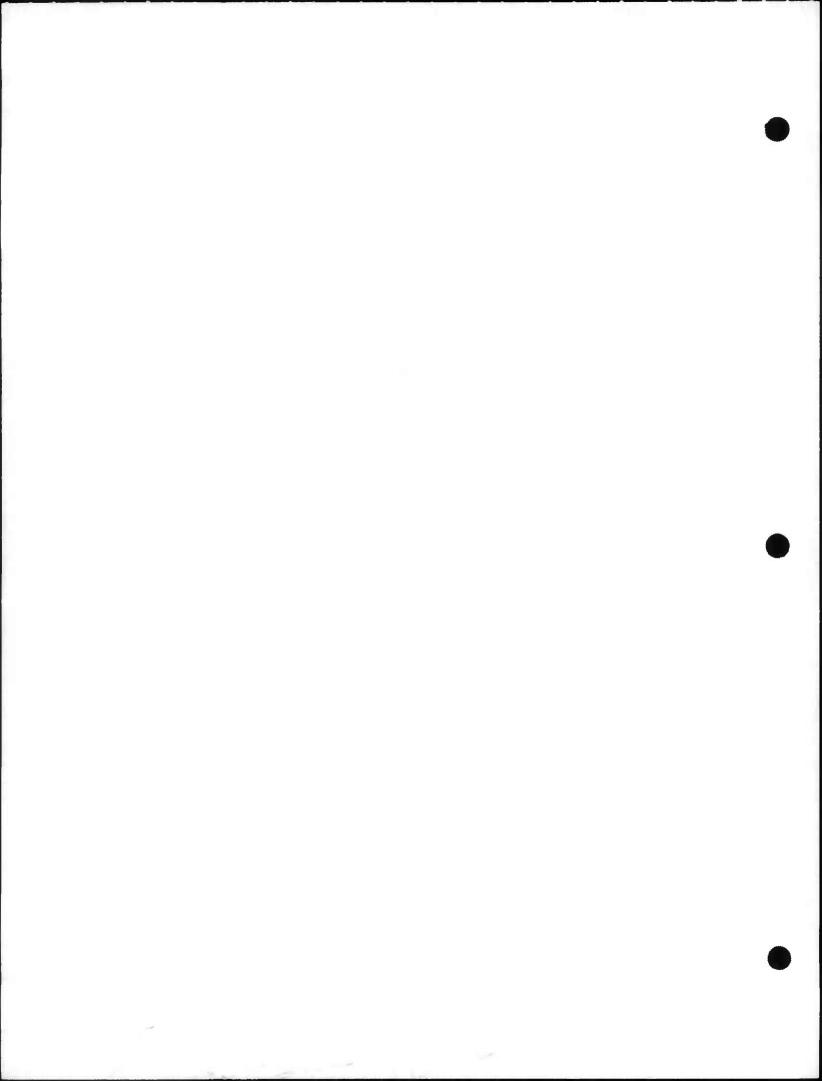


			1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGIE		08	8863	
4			1. DECEDENT'S NAME (First, Middle, Les	·				2. DATE OF DEATH	DAY Y	YEAR 3. T	TIME OF DEATH	
			DONALD 4. SOCIAL SECURITY NUMBER	RICHAI		MINN		02 1	4 19	93 8	•40 p	
	모		577-70-1508	1 💢 M 2 🗌 F		ONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 4-25-56		Country)	ngton, DC	
	3 should	œ	9a. FACILITY NAME (If not institution, give				OR LOCATION OF D	EATH	9c. COUNTY	Y OF DEATH	1	
	. 2,	20	419 JINCOLN A				VILLE		MONTGOMERY			
	t. Pages	DIRECTOR	Maryland Mon	tgomery		town or loca er Spri					LIMITS? YES 2 XNO	
	permit.	₹ ¥	10e. STREET AND NUMBER				f. ZIP CODE		10g. CITIZE	N OF WHAT		
	ian. -transit	FUNERAL	9103 Kingsbury	12. WAS DECEDENT EVER II		1	20910				States	
	MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit notified at once.	BY FU	1 Never Married 2 Married 3 Widowed 4 Ovorced	FORCES? 1 YES	2 NO	If yes, sp	DECEMBENT OF HISPA Decify Cuban, Mexico B 2 2 NO Specia	NIC ORIGIN? (Specify Y an, Puerto Rican, etc.) /y:	ps or No— 14	Black, Wh Specify:	American Indian, nite, etc.	
	1215 r attenuse as	E	15. DECEDENT'S EC (Specify only highest gra	DUCATION de completed)	16a. DECEDENT'S US (Give kind of wor	k done during me	ON ost of working	16b. KIND OF B	USINESS/INDUS		.100	
	D 2 spital o	COMPLET	Elementary/Secondary (0-12) 12 years	College (1-4 or 5+)	Elect	ronics	Tech	Elec	tronics	š		
	the hose detach	NOS	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Maide	n Sumame)			
	2 2 2 E	BE	Donald Minnoch 19s. INFORMANT'S NAME (Type/Print)					ra Lou Co				
		10	Barbara L. Minne	och	Same a		and Number or Rural	Route Number, City or To	wn, State, Zip Co	ode)		
	BALTIMORE, after death. Page 6 may be by the funeral director, page moval. cal examiner must be		20a. METHOD OF DISPOSITION 1		PLACE AND DATE OF OPERLY, Cremetory or other LIDUIDAN C					CATION — City or Town, Stata VER Spring,		
,	ALTIN death. Page tuneral dir death. Page tuneral dir examiner		21. SIGNATURE OF FUNERAL SERVICE			22, NAME A	ND AODRESS OF FA	VCILITY		3,	,	
,	m = 28		, Dell- 1	3. CW1	M00827	033 C	ict Avo	Services,	nrina	MD 20	0910	
(24 hours filled in this		23. PART 1. Enter the diseases, o abook, or heert failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that caused b. List only one ceuse on e	ech line.		ode of dying, suc	th as cardlec or rea	piratory arrest	ŧ,	Approximate Interval Between Onset and Death	
	C 68760, executed within and completely o burial, creman matic event,		,	OUE TO (OR AS A	CONSEQUENCE OF):							
	exect and to but to but	ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b. Chronic A DUE TO (OR AS A	LCOHOLISM CONSEQUENCE OF):							
	P.O. B th certificat ending phy I Hygiene s or other	CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
,	0 2 5 2 5	AL C	PART II. Other algnificant condition	one contributing to death b	ut not resulting in	the underlyin	g cause given in	Part I. 24a. WAS A	N AUTOPSY	24b. WER	E AUTOPSY FINDINGS	
	any any	EDIC/	Chronic Narcot	ism				PERFO	2 NO	COM	LABLE PRIOR TO IPLETION OF CAUSE DEATH?	
*	w requires been sign or, of Heal	Σ						— `		×	DAES 5 - NO	
	ITAL F N: The law ficate has be State Dept. Item 23 s	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26, PI	LACE OF DEATH (Ch	eck only one)				
	도 등 을 들 .	PHYS	1 TYES 2 NO 27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Outp		☐ Nursing Horn	ne 5 X Residence	8 Other (Specify) 28d. OE\$CRIBE HOW	IN HIM COOK	250		
	ON OF DING PHYSICI After this cer death with the	BY PI	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	Y WC	YES 2 NO	28d. DESCRIBE HOW	INJURY OCCUR	(EO		
	TISIC STOR: A after de		3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, stre	et, factory, offic	:0	281. LOCATION (Street City or Town, State	and Number or	Rural Route I	Number,	
	14 2 15 15 15 15 15 15 15 15 15 15 15 15 15	MPLETED		SICIAN: To the best of my knowl								
((TO THE FUNERAL DE filed within 72 IMPORTANT: If	8	2X MEDICAL EXAMI	NER: On the basis of examination	and/or investigation,	in my opinion, c						
1	O THE I	B	296. SIGNATURE AND TITLE OF CERTIFI	- W			29c. LICENSE NUI		29d. DATE S			
W	FFAS	٩	30. NAME AND ADDRESS OF PERSON W	THO COMPLETED CALISE OF OE			0.C.				/1993	
T			31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGN	ATURE	Stree	t, Balt	imore, M	laryla	nd	21201	
			MAR 16 '93	Julia Davidson	- Handell						_	



TO BE COMPLETED BY FU	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	INPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
the funeral director, page 5 should be detached for use as the burial-R val.	IN THE FUNE W. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-town in the state Dept. of Health and Memal Hyglene prior to burial, cremation, or removal.
er death. Page 6 may be retained by the hospital or attending physici	IN THE WARNING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicial
BALTIMORE, MARYLAND 21215-0020	DIVISION OF VITAL RECORDS, P.O. BOX 68760,
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	1 - STATE REGISTRAR	STATE OF MA	ARYLAND / DI CER	EPARTN	MENT OF	HEALTH	AND ME	NTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)							. DATE OF DEATH			3. TIME OF DEATH
		MOYER					N	MONTH DA		YEAR	845 A "
			L AGE (In yrs. lest bir		UNDER 1 YEAR	IF UNDER	24 HRS. 7	Month, Day, Year)	- 1	BIRTH	PLACE (State or Foreign
	210-00-9030	1 - M 2 - F	74	YRS.	330 400		A	APRIL 11.	1918		INGTON D.C.
<u></u>	9e. FACILITY NAME (If not institution, give street			9t	b. CITY, TOWN	OR LOCATIO	ON OF DEAT	Н	9c. COUNT	Y OF DE	EATH
DIRECTOR	3972 BEL PRE ROAD #5 SILVER SPRING MONTGOMERY										MERY
EC.	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY										
	MARYLAND MON	NTGOMERY		S	ILVER	SPRTN	IG			- 1	LIMITS? 1 YES 2 NO
AL	PIARY LAND MONTGOMERY SILVER SPRING 1 ☐ YES 2 ☐ NO 100. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?								HAT COUNTRY?		
FUNERAL	3972 BEL PRE ROAD	# 5				209	06		US	SA	
2	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT I	EVER IN U.S. ARMED)	13. WAS DE	CENDENT O	F HISPANIC	ORIGIN? (Specify Yes Puerto Rican, etc.)		4. RACE	— American Indian, White, atc.
ВУ	3X Widowed 4 Divorced	IF YES, GIVE WAR				2 ∑ NO		day to thomis asm)		Specif	y:
	15. DECEDENT'S EDUCA	TION	16a DECEO	ENT'S HEI	UAL OCCUPATI	ON		16b. KIND OF BUS		WHI	TE
COMPLETED	(Specify only highest grade co	College (1-4 or 5+)	(Give k	ind of work NOT use re	done durina m	ost of working	g	TOD. KIND OF BUS	INESS/INDU	SIRY	
립	12	Conlege (I-4 of 5 T)		HOME	MAKER						
S	17. FATHER'S NAME (First, Middle, Last)			HOTTE	MICEIC	18. MOTH	IER'S NAME	(First, Middle, Maiden :	Sumame)	-	
BE C	FRANK STRE	EEKS				L	OUISE	WEIS	3		
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. M	AILING AD	ORESS (Street			te Number, City or Town		Code)	
۴	JUDY L. GARGAN	(DAUGHTE	R) 169	09 CA	ASHELL	ROAD	OLN	EY, MARYI	AND	208	32
	20a. METHOD OF DISPOSITION 1) Burlai 2 Cremation 3 Remove	al from State	20b. PLACE AND cemetery, cremete	DATEOFD	SPOSITION (N				CATION — CI		
	4 Donation 5 Other (Specify)		CEDAR	HILL	CEMET		i	3/17 SUIT	LAND,	MA	RYLAND
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE			FRANC	ND ADDRES	COLT.	INS FUNER	AT. HO	MF	TNC
	Oteven D.	Styrical									,MD 20901
	23. PART i. Enter tha diseeses, or cor shock, or heart failure. Lie	mplications that c	coused the death.	Do not	enter tha me	da of dyl	ng, such s	s cardiac or respin	ratory arres	st,	Approximata
	THREEDIATE ONLINE (EL				1		1	,	4		intarvsi Between Onset and Death
	disease or condition	Chro	nee d	Usi	Treuc	tw	e les	ngdes	eas	e	10 urs
		OUE TO (O	R AS A CONSEQUE	NCE OF):							
ON	Sequentially list conditions, b.	OUE TO (O	R AS A CONSEQUE	IOF OF							
CERTIFICATION	if sny, leeding to immediate cause. Enter UNDERLYING	002 10 (01	n as a conscouer	NCE OF):							
FI	CAUSE (Disease or injury that initiated events	DUE TO (O	R AS A CONSEQUEN	NCE OF):							
E	resulting in death) LAST										1
	PART ii Other significent conditions	annielle vale e an et			COLUMN TO STUDE	Street Control	ALEXALE A			_	
PHYSICIAN: MEDICAL	PART II. Other significent conditions	contributing to de	ath but not resu	Iting in II	Luci	g causa g	tven in Par	1 I. 24a. WAS AN A PERFORE			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	het	ac n	eau -	rai	un	Q _{in}		1 - YES 2	NO		OF DEATH?
Σ	The total	weep	aus	ea	10			43			1 _ YE\$ 2 _ NO
A	25. WAS CASE REFERENCE TO MEDICAL	cer	Misse	2						1	
S	EXAMINER?	HOSPITAL:			THER:		ATH (Check				
¥	27. MANNER OF DEATH	28s. DATE OF IN-		b. TIME OF		URY AT		Other (Specify)			
	1 Netural 5 Pending	(Month, Day,	Year)	INJURY		PRIC?		Id. DEŞCRIBE HOW IN	JURY OCCU	RED	
BY	2 Accident Investigation 3 Suicide & Could not be	26e, PLACE OF I	NJURY — At home,	form, stree				if. LOCATION (Street as	nd Number or	Burni Br	outo Mumber
	4 Homicide 6 Could not be	building, etc	: (Specify)		.,,	•	1	City or Town, State)	TO NUMBER OF	nurai no	oue rumper,
COMPLETED	290. CERTIFIER	N: To the heat of -	. beautains doub								
₹ I	(Check only one) 1 CERTIFYING PHYSICIA MEDICAL EXAMINER:										
	29b. DECHATURE AND TITLE OF CERTIFIER				y opinion,						
H H	Dera A.	Sons	aster	6%	WAT -	29c, LICE	NSE NUMBE	2/			(Month, Day, Year) 2 - 9.3
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUDE	OF OEATH (ITEM 27)	(Type, Prin	70	4	21	21			2-10
	GEORGE F. SENGSTA		3929 F			17T2 *	TITE A CC	M MARKE :-		00-	1
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE	LKKA	KA DKI	VE W	VHEAT(ON MARYLA	ND 209	906	
	MAR 17 '93	gulia Da	widson Pan	dell							



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DIVISION OF VITAL RECORDS, P.O. BOX 6876	TEMDING
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31. DATE FILED (Month, Day, Year)
MAR 17 '93

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	1 - FOR STATE REGISTRAR	STA	TE OF N	MARYLAND C	DEPAR					MENT	AL HYGIEN			
1	1. DECEDENT'S NAME (First, M	liddle, Last)	٨							2. DAT	E OF DEATH	AY	YEAR	3. TIME OF DEATH
	PETER			MAGRA	2					3	3 12		93	5:00 A
	4. SOCIAL SECURITY NUMBER 012-16-7175			6. AGE (In yrs. ia	• • • • • • • • • • • • • • • • • • • •	IF UNDE	DAYS	IF UNDER	24 HRS.	7. DAT	E OF BIFITH oth, Day, Year)		8. BIRTHI Country	PLACE (State or Foreign
	Li .	- 21	M 2 🗌 F	75	YRS.				131-1	0ct	3, 19	17	Mas	sachusetts
DIRECTOR	9a, FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF													
ECI	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 16c. CITY, TOWN OR LOCATION													
HIC	MD	Montgome	ry				Spr							10d. INSIDE CITY LIMITS? 1 XES 2 NO
	10e. STREET AND NUMBER		_				101	. ZIP COD				10g, CIT		HAT COUNTRY?
FUNERAL	3330 N. Leis	ure Worl	d Blv	d, #120)			2	2090	6		-	SA	
N N	11. MARITAL STATUS		S DECEDEN	T EVER IN U.S. AI	RMED	13	WAS DEC	ENDENT O	F HISPAN	IIC ORIG	ilN? (Specify Ye	s or No	14. RACE	American Indian,
ВУ Е	1 Never Married 2XXMs 3 Widowed 4 Divorce	IF V	RCES? 1 (ES, GIVE W	X YES 2 AR OR DATES	NO		If yes, sp	ecify Cube	n, Mexical Specify	n, Puert :	o Rican, etc.)		Black. Specif	, White, etc.
					WW I				1111111					White
IEI	(Specify only h	ENT'S EDUCATION ighest grade complete		(0	ECEDENT'S Sive kind of a. Do NOT u	Work done	during mo	ON ist of working	ng	10	66. KIND OF BU	SINESS/IN	DUSTRY	
7	Elementary/Secondary (0-12) Colleg	2 (1-4 or 5 +)	ales	se remed.	,				Retai	1		
COMPLETED	17. FATHER'S NAME (First, Midd	in Last)						40 MOT	UEDIO MA	AF (Fine	, Middle, Maiden			
Ö	Michael P.										ie Pani	,		
BE	19a. INFORMANT'S NAME (Type	/Print)		19	b. MAILING	ADDRES	SS (Street a				mber, City or Tox		n Codel	2090
5	Catherine	Magras		3	330 1	N. L	eisu	re Wo	rld	B ₁ v	d, #12	0 Si	lver	Spring, MD
	200. METHOD OF DISPOSITION		1303	20b. PLACE	AND DATE	OF DISPO	SITION (Na			1	_		City or Tov	
	1-1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		n State	T.in	ematory or o	Com	otors	17	03	1161	03 1101	orbi	11 M	Ά
7	21. SIGNATURE OF FUNERIAL S	ERVICE CICENSEE	-			22	. NAME A	NO ADDRE	SS OF FA	CILITY	lines/R	inal	li Fu	neral Home
	Toins	Y As	X			1	1800	New	Hamr	shi	re Ave	. Sil	lver	Spring, MD
	23. PART /. Enter the dise	ases, or complic	ationa tha	t caused the de	eath. Do									Approximata
	immediate cause (Final	rt fallure. List oni	y one cau	se on each lin	е.									Intarval Between Onset and Deat
	disease or condition	9	PEC	IRE IT	A	7 0 4	11)	P	رعل	A. 1. 10			
	resulting in death)	8	DUE TO	(OR AS A CONSE	QUENCE O	F):	114.5		4		1101011	'		40N745
z	Tarana and the same and the sam	6 h	1427	(CRAS A CONSE	L'5	•	061	16N-	TIA					4600
ERTIFICATION	Sequentially list condition if any, leading to immedia	ite 💮	DUE TO	(OR AS A CONSE	QUENCE O	F):								
2	cause. Enter UNDERLYING CAUSE (Disease or Injury													
E	that initiated events resulting in death) LAST	1	DUE TO	(OR AS A CONSE	QUENCE O	F):								
5		d												
اد	PART II. Other aignificant	conditions contr	ibuting to	death but not	reauiting	in the u	nderlying	g cause (given in	Part i.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
MEDICAL											1 YES			AVAILABLE PRIOR TO COMPLETION OF CAUSE
Ä												4.0	1	OF DEATH?
ä														
PHYSICIAN:	25. WAS CASE REFERRED TO A EXAMINER?		PITAL:					ACE OF D	EATH (Chi	ick only	one)			
YSI	1 TES 25 NO			ER/Outpatient	DOA	OTHE	R: Irsing Hom	e 5 □ Re	sidence	6 🗆 Ott	her (Specify)			
PH	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 28c. INJURY AT WORK?													
B	2 Accident Investigation " 1 Yes 2 NO													
	5 Cul-14 1 286 PI ACE OF IN II IPV _ At home form office 1 004 1 004 704 (0 44 4 4 0 4 5 4													
H	AL OFFICIAL													
AP.		ING PHYSICIAN: To												
COMPLETED	2 MEDICA		basis of si	camination and/or	Investigation	on, in my	opinion, d	eath occur	ed at the	time, de	ts and place, as	nd due to ti	he cause(s)	and manner as stated.
BE (296. SIGNATURE AND TITLE OF	CERTIFIER	A					29c. LICE	NSE NUM	BER	,	29d. DAT	E SIGNED	(Month, Day, Year)
2	Meite	Orangel	(W)					9	089	TY			3/0	193

3720 TAPASONT

APLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE
Guna Davidson Randelle

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attending physician. use as the P detached he funeral director, page 5 should be retained by Page 6 the attending physician and completely filled in by the Mental Hyglene prior to burial, cremation, or removal. ING PHYSICIAN: The law requires that the death certificate be signed by the Shows ? t. of h Dept. This certificate has with the State D item 0 After 1 death OPPECTOR: A Item 28

burial-transit permit. Pages 1, 2, 3 should

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TO THE FUNERAL DISPLAY
TO THE FUNERAL DISPLAY
IMPORTANT: IT IN

ITEM: 7. PER F.H. G-698 4/21/93 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH 3/13/93 1. DECEDENT'S NAME (First, Middle, Lest) 3. TIME OF DEATH 10:33 P Maria S. Medina ? 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH DAYS HOURS 07. Day, Year) 1 M 2XXF 578-80-8129 73 E1 Salvador 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Holy Cross Hospital Silver Spring Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Silver Spring Maryland Montgomery 1 YES 2 NO 10e, STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g CITIZEN OF WHAT COUNTRY? 20901 901 Arcola Ave Perm. Res.-USA 11, MARITAL STATUS
1 Never Married 2 Merried 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-if yea, specify Cuben, Mexican, Puarto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 NO 14. RACE — American Indian, If yes, specify Cuben, Mexican, Puerto Rican, IF YES, GIVE WAR OR DATES Specify: White Specify: BY 3 Widowed 4 Divorced Spanish COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY intary/Secondary (0-12) College (1-4 or 5+) 11 0 Homemaker Housewife 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Carlos Medina Romana Pineda 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Rubenia Bringas 1801 Clydesdale P1. Washington, DC 20009 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE cemetery, cremetery or other place)
Gate of Heaven Cemetery 3/17/93 Silver Spring, MD 4 Donation of (f) Other (Specify) MAL SERVICE LICEN 21. SIGNATU 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Spring. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximsta shock, or hasrt failure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final a. RESPIRATORY
OUE TO (OR AS A CONSEQUENCE OF disease or condition FAILURE 2 WEEKS resulting in death) CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING RTERIOSCUEROTIC RENAL DISEASE CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TYES 2 NO opetient 2 - ER/Outpetient 3 - DOA me 5 Residence 6 Other (Specify) 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 26b, TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) ETED 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide COMPL

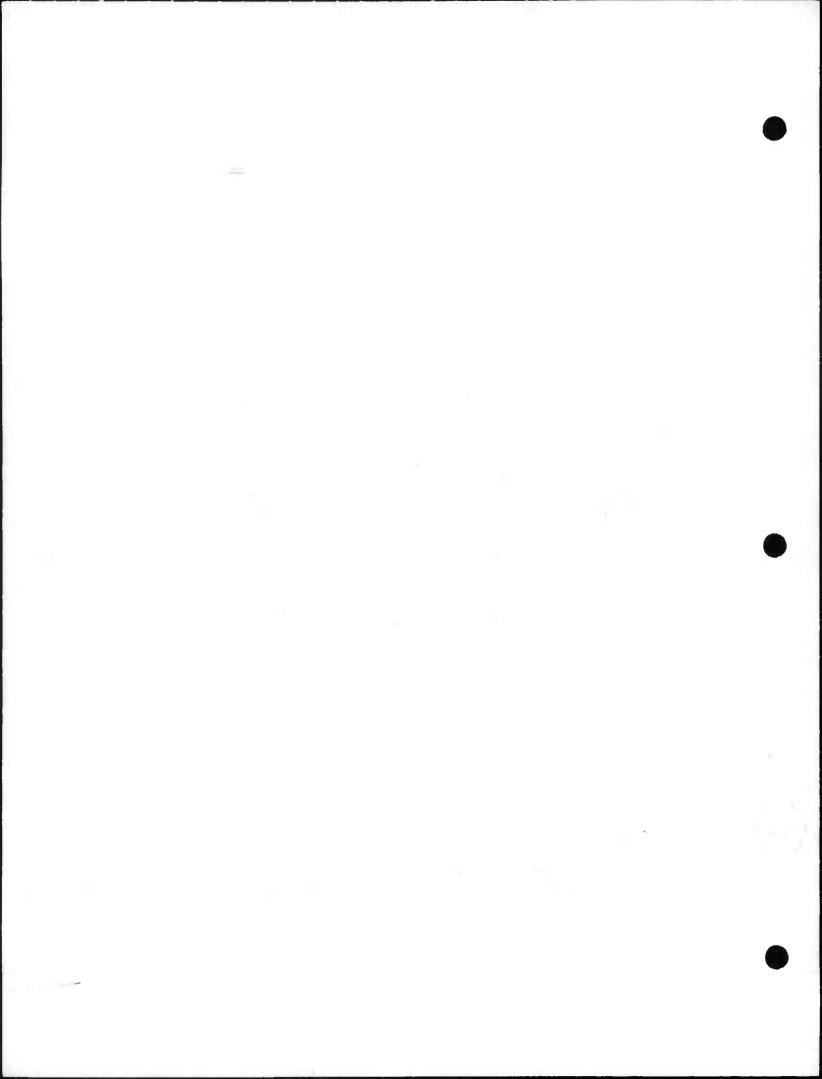
2 MEDICAL EXAMINER: On the be 296. SIGNATURE AND ESS OF PE

1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the tima, date end place, and dua to the cause(a) and manner as stated. in my opinion, death occured at the time, date end place, end due to the cause(e) end menner as stated.

> 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 14 MARCH 1993

Walter Ε. Goozh, MD. 2309 Shorefield Rd Wheaton, Maryland 20902

31. DATE FILED (Month, Day, Year) MAR ,O3 32. REGISTRAR'S SIGNATURE who Davidson Rondoll



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death. Page 6 may be r	ral director, p	
irs after death	n by the fune	removal
within 24 hou	pletely filled i	remation, or
be executed y	sian and com	or to burial, c
th certificate	ending physic	Il Hypiene pri
s that the dea	ned by the att	ith and Menta
e law requires	has been sign	Dept. of Hea
HYSICIAN: Th	his certificate	with the State
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

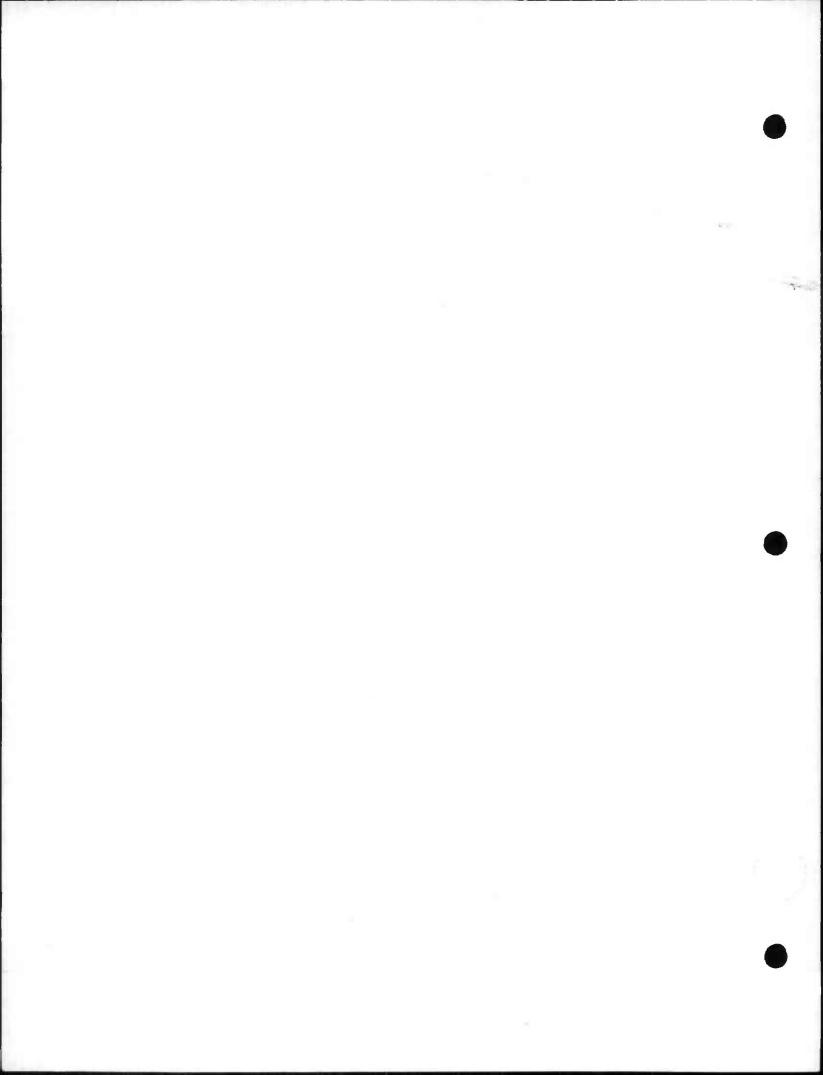
CERTIFICATE OF DEATH

	1 - FOR STATE REGISTRAR	STATE OF MARYL	LAND /	DEPAR	TMENT (OF 1	ALTH AND		GIENE 6. NO.) (0001	
	1. DECEDENT'S NAME (First, Middle, Lest)							2. DATE OF DE	TH.		3. TIME OF DEAT	гн
	GRACE LOUISE	MUZZY						MARCH	14, 19	93	11:50	P. M
	4. SOCIAL SECURITY NUMBER		(In yrs. las	t birthday)	IF UNDER 1 Y		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIFT (Month, Day,)	ГН		HPLACE (State or Fo	
	216-60-2527		8	YRS.	MONTHS D	AYS	HOURIS MEN.	Novembe			.,, Washingt	D.
-	9e. FACILITY NAME (If not institution, give at						LOCATION OF D		9c. C0	DUNTY OF E	DEATH	1.0
DIRECTOR	MANOR Care Nursi	ng Center			Silve	r S	pring		Mo	ntgom	ery	
2	10a. STATE 10b. COUNTY	1		10c. CITY	, TOWN OR I	OCATIO	ON .				10d. INSIDE CITY	,
HE	Maryland Mont	gomery		Burt	onsvi	.11e	!				LIMITS?	
RAL	10e. STREET AND NUMBER					10f. 2	ZIP CODE		10g. C	ITIZEN OF	WHAT COUNTRY?	
E .	3000 Brownstone (Court				2	0866		Un:	ited	States	
FUNE	11. MARITAL STATUS	12. WAS DECEDENT EVER I FORCES? 1 YES	NU.S.AR	MED				NIC ORIGIN? (Spec		14. RAC	E — American India	en,
BY	1 Never Married 2 Merried 3 Nover Married 4 Divorced	IF YES, GIVE WAR OR D					NO Specif	nn, Puerto Rican, e ly:	tc.)	Spec	Hv.	
0	15. DECEDENT'S EDUC	CATION	40. 00		1						ćasian	
ETE	(Specify only highest grade	completed)	(Gi		USUAL OCCL ork done duri			16b. KIND (OF BUSINESS/I	NDUSTRY		
급	Elementary/Secondary (0-12)	College (1-4 or 5+)		memak					Own Hor	m e		
COMPL	17. FATHER'S NAME (First, Middle, Last)		110				18. MOTHER'S NA	ME (First, Middle, I				
E G	Albert Allemann						Ruth W	atson		,		
8	19a. INFORMANT'S NAME (Type/Print)		198	. MAILING	ADORESS (S	treet and	l Number or Rural	Route Number, City	or Town, State, .	Zip Code)		
2	Ruth L. Hill	(Daughter)	3	000 E	rowns	ton	e Ct. B	urtonsv	ille, 1	Md. 2	0866	
200	20e, METHOD OF DISPOSITION 1 Burlel 2 Cremetton 3 Remo	oval from Stele	b. PLACE	NDDATEO	FOISPOSITIO	ON (Nam	e of	OATE 2	Oc. LOCATION	— City or To	own, State	
	4 Donation 5 Other (Specify)	F	ort	Linco	In Cr			-16-93	Brenty	wood,	Marylan	ıd
	21. SIGNATURE OF FUNERAL SERVICE LIC	12	-				ADDRESS OF FA	Funera	Home			
e X	▶ Lemis a Zi	pelow								lver	Spr.,Md.	209
BOICS	23. PART I. Enter the diseases, or o	omplications that cause	d tha de	ath. Do n	ot antar the	mode	of dying, suc	h as cardiac or	respiratory a	arrest,	Approxima	eta
or other traumatic event, the medical examiner must be notified at ERTIFICATION TO BE (IMMEDIATE CAUSE (Final	List only one cause on e									Onset and	
5	disease or condition resulting in death)	PNEUM	MOI	MA								
EVE I		DUE TO (OR AS	A CONSEC	DUENCE OF):							
N N	Sequentially list conditions,	b										
ATI	if any, leading to immediata cause. Enter UNDERLYING	DUE TO (OR AS /	A CONSEC	NUENCE OF):						-	
FIC	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS /	A CONSEC	UENCE OF):						_	_
CERTIFICATION	resulting in death) LAST				í .						İ	
Ä	PART II. Other algorificant conditions	a contributing to death t	out not ra	asulting in	tha under	rlying	cause given in		AS AN AUTOPS ERFORMED?	Y 24b	WERE AUTOPSY FI	
EDIC								101	ES 2XXNO		OF DEATH?	AUSE
: MEC											1 - YES 2 - F	10
의돌	25. WAS CASE REFERRED TO MEDICAL											
YSICI/	EXAMINER?	HOSPITAL:			OTHER:		CE OF DEATH (Ch					
	1 YES 2 NO	1 Inpatient 2 ER/Out	patient 3	26b. TIME		Home c. INJUF		6 Other (Special		- COURT		
	1 Natural 5 Pending	(Month, Day, Year)		INJU	IRY	WORK		26d. DESCRIBE	TOW INJUNT O	ССОНЕВ		
	2 Accident Investigation 3 Suicide & Could and be	26+. PLACE OF INJURY	r — At hor	me, farm, at				281. LOCATION (Street and Numb	ner or Runal I	Brute Alumber	
이쁘	4 Homicide determined	building, etc. (Spe-	cify)					City or Town,	State)	ror or ribrar r	tode warnon,	
MPLETE	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my know	dedos de	oth conveni	d ad Aba Alaa	detection	4.6 5.44		,			
COMPI		R: On the basis of examination									a section beautiful	and a ref
8	29b. SIGNATURE AND TITUE OF CENT FIELD					_						ateu.
) BE COI	TULIST	un Mi	D				P9c. LICENSE NUI	1. 2	29d. D/	S / /	(Month, Day, Year)	
일	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEN	4 27) (Type	Print)		V>13	00)		2/1-	2112	
	11161 Now He	anshveA	V6		VEV	Sa	va-	MD 2.	0904			
-	31. DATE FILED (Month, Day, Year)	34. REGISTRAR'S SIGN				7	1	- 0	1 - 1			
	MAR 17 '93	Julia David	Som A	andeM								

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

physician.	e burial-transit permit. Pages 1, 2, 3 should		
s after death. Page 6 may be retained by the hospital or attendi	hould be de		the mattheward of same
within 24 hours after death. Page 6	ity filled in	cremation, or removal.	the first of absence and because the forest and address the second of the second and the second as
hat the death certificate be executed	1 by the attending physician and complete	and Mental Hygiene prior to burial,	are latiness on address described as
ING PHYSICIAN: The law requires that the death cer	When this certificate has been signed by the atten-	wath with the State Dept. of Health	1
DOWNER HIS STALL OR ACTEND	TO THE HUNERAL DIRECTOR: A	be filed within 72 hours after 6	SAMPLE OF REAL OF LAND OF LA

	1 - STATE REGISTRAR	STATE OF I					EALTH DEAT		NTAL HYGIEN REG. NO.	E		
20	1. DECEDENT'S NAME (First, Middle, Lest)	MARI	E L. McA	LEAR				2	DATE OF DEATH DATE OF ARCH 13.	1993	YEAR	3. TIME OF DEATH 2:13 P M
	4. SOCIAL SECURITY NUMBER 579-54-9683	5. SEX 1 M 2 F	6. AGE (In yrs. les	t birthday) YRS.	IF UNDER	DAYS	IF UNDER HOURS	24 HRS. 7.	DATE OF BIRTH (Month, Day, Year) EPT. 29, 19		8. BIRTH Countr	IPLACE (State or Foreign
OB	9a. FACILITY NAME (If not institution, give s HOLY CROSS HOSP						R SP	ON OF DEATH	Н		UNTY OF D	eath OMERY
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN	OR LOCAT	ION					10d, INSIDE CITY
	MARYLAND MO	NTGOMERY			SILV		PRING		·	Maria de la composición dela composición de la composición de la composición dela composición de la composición de la composición dela composición dela composición de la composición de la composición dela composición de la composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición de		LIMITS? 1 YES 2 NO
FRA	8811 COLESVILLE ROAD #505					101	20910			10g. CI		VHAT COUNTRY?
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married			MED		If yes, sp	ENDENT O	F HISPANIC	ORIGIN? (Specify Yes	or No-	USA 14. RACE Black	E — American Indian, k, Whita, etc.
D BY	3 Widowed 4 Divorced		AR OR DATES	OFFITTION .			2 🔀 NO	Specify:	Υ			HITE
COMPLETE	(Specify only highest grade		·) (G		work done se retired.)	during mo	N st of workin	g	16b. KIND OF BUS	HNESS/IN	IOUSTRY	
₹	17. FATHER'S NAME (First, Middle, Lest)	1	SEC	RETA	.RY				FEDERAL		/ERNM	ENT
	GEORGE V. MCALEA	D					18. MOTH		(First, Middle, Maiden	,		
BE	19a. INFORMANT'S NAME (Type/Print)	K	19	b. MAILING	ADDRES	S (Street a	nd Number		L. McDEV		in Code)	
욘	HELEN M. JOHN	(SIST	T I									MD 20910
	20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION / Name of DATE 20c. LOCATION — City or Town, State											
	21. BECHATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC.											
	Mach L.	illell			50	0 UN	IVER	SITY I	BLVD.,W.	SIL.	SPR.	INC. ,MD.20901
	23. PART I. Enter the diseases, or shock, or heart failure.	complications that List only one cau	t caused the de se on each line	ath. Do	not enter	the mo	de of dyle	ng, such a	s cardiac or respi	ratory a	rreat,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	a	Cordin	- ve	sei1	reto	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	DV	veit			Onset and Death
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF): //						Jeans.					
MEDICAL (PART II. Other significant condition	discontributing to	In	esulting Seel	pa			en in Par	Tt I. 24e. WAS AN PERFOR	MED?	246.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 D NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	- Engo	this	Lev	7	Fire	ACE OF DE	TH (Check	ank one	1.		
SIC	EXAMINER? 1 YES 2 ND	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHEI	R:	111 11		Other (Specify)			
	27. MANNER OF OEATH 1 Natural 5 Pending	28a. DATE OF (Month, D	INJURY ay, Year)	286. TIN		28c. INJ WO		28	Id. OESCRIBE HOW IF	JURY OC	CCUREO	
red BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE O building,	F INJURY — At ho etc. (Specify)	me, farm,	street, fact				M. LOCATION (Street a City or Town, State)	nd Numbe	er or Rural F	Route Number,
COMPLETED									the cause(s) and man			
8	2 MEDICAL EXAMINE		samination and/or i	investigatio	on, in my o	opinion, d						
O BE	296. SIGNATURE AND TITLE OF CERTIFIE	Grania	w	99			D#	PI8	*	29d. DAT	TE SIGNED	(Month, Day, Year)
10	HU CO GO, GA	A LAN	OF DEATH OF	M 27) (7500)	Penk	ù-y	010	rc	5-5-1	40	2	20910
	31. DATE FILEO (Month, Day, Year)	32. REGISTRA	R'S SIGNATURE	יו. מל	00							



permit. Pages 1, 2, 3 should

detached for use as the burial-transit

page 5 should be notified at

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OULS	dinb	or ref
24 h	, fille	ilon.
withIn	npletely	cremai
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. P	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral	hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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ate b	nysici	prio
certific	fing ph	ygiene
death	atten	ental H
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E :	icate	State
CIA	ertif	the
PHYS	this o	MA.
DING	After	death
TEN	TOR:	after
OR A	DIREC	hours

item 23 shows any injury, or other traumatic event, the

6

MPORTANT: If Item 28 is merked,

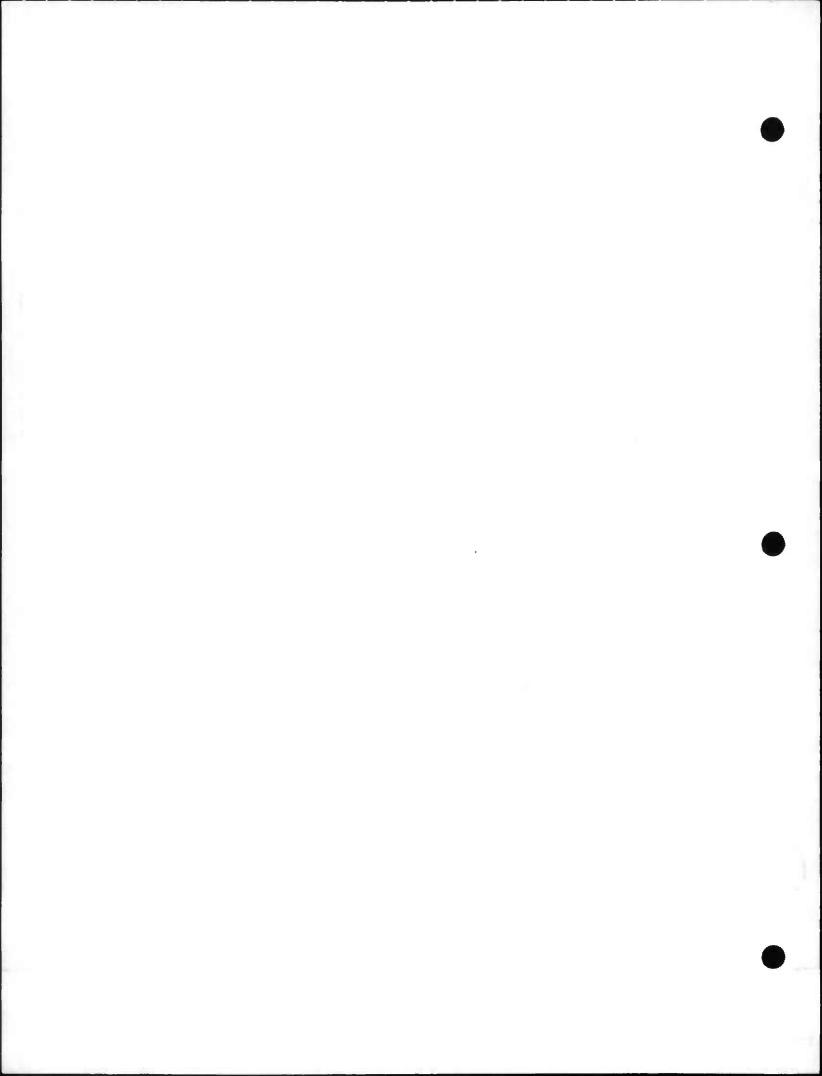
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MARCH GEETRUDE MALONEY 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH
(Month, Day, Year)
(9-27-/5 IF UNDER 1 YEAR IF UNDER 24 HRS. 387.14.8413 1 - M 2 X F 9b: CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS 10c. CITY, TOWN OR LOCATION Maryland Anne Arundel Annapolis 10e. STREET AND NUMBER 10f ZIP CODE 2005 Kenwood Road 21402 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2
IF YES, GIVE WAR OR DATES 2 NO 1 Never Married 2 Married 1 TYES 2 NO Specify 3 Widowed 4 Divorced 1951 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) college librarian 17. FATHER'S NAME (First, Middle, Last) Albert Mountain Gertrude McGinn 19e. INFORMANT'S NAME (Type/Print) Richard F. Maloney 20a, METHOD OF DISPOSITION
1 A Buriel 2 Cremation 3 Ren
4 Donation 8 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Arlington National Cem. Mar. 18,93 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Devol Funeral Home shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) neumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I.

3. TIME OF DEATH 8:04 8. BIRTHPLACE (State or Foreign Wisconsin 9c. COUNTY OF DEATH ANNE APUNDEL DIRECTOR 10d. INSIDE CITY 1 YES 2 | NO FUNERAL 10g, CITIZEN OF WHAT COUNTRY? USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. Specify: BY white ETED 16b. KIND OF BUSINESS/INDUSTRY COMPL Georgetown University 18. MOTHER'S NAME (First, Middle, Maiden Surname) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 2005 Kenwood Road, Annapolis, MD. 21402 20c. LOCATION — City or Town, State Arlington, Va. 2222 Wisconsin AVe., N.W., Washington, DC 23. PARTI. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between Onset and Death CERTIFICATION 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 TYES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) **EXAMINER?** HØSPITAL:
| Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 TES 2 ND me 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE DF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 🗌 Sulcide 8 Could not be determined 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) BE COMPLETED 4 Homicide 29e. CERTIFIER (Check only one) CERTIFIER (Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner se atsated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) 041339 ~ m 3 2 AND ADDRESS OF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARMS, mEdien1 ANNE JAM23 mD HRUNDEL 32. REGISTRAR'S SIGNATURE MAR 19 '93 Julia Savidan Rando 12

TO THE HONETON: After this certificate has been signed by the attenting physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is merked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

	1 - STATE REGISTRAR	STATE OF MAR		RTMENT OF		MENTAL HYGIE	[] '	08870
	1. DECEDENT'S NAME (First, Middle, Last)		TONIE C	DEATH	2. DATE OF DEATH		3. TIME OF DEATH
	ETHEL (G. MCGRATH				March 17	1993	EAR
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	AGE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.	BIRTHPLACE (State or Foreign
3	577-09-0249	1 🗆 M 2 🗶 F	93 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)		Country) Massachusetts
	Se. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TOWI	OR LOCATION OF E		9c. COUNTY	
S S	Sacred Heart Ho	me, Inc.		Hyat	tsville		Princ	ce Georges
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN							
I BI	120.00		10c. CIT	Y, TOWN OR LOC				10d. INSIDE CITY LIMITS?
	Maryland Prin	nce Georges		Hyatts	Ville Of ZIP CODE			1 YES 2 NO
RA	5805 Queens Cha	nol Dood			20782-3	000	10g. CITIZEI	N OF WHAT COUNTRY?
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EV	FO IN II STADMEN	12 WMC 0		NIC ORIGIN? (Specify Y		U.S.A.
	1 🔀 Never Married 2 🗌 Married	FORCES? 1 1	YES 2 TNO	If yes,	pecify Cuban, Mexic	en, Puerto Rican, etc.)	14 or No — 14	RACE — American Indian, Black, White, etc.
B	3 Widowed 4 Divorced	IF TES, GIVE WAN C	OH DATES	1 1 1	S 2 M NO Spec	ny:		Specify: White
COMPLETED	15. DECEDENT'S ED (Specify only highest grad		16a. DECEDENT'S	USUAL OCCUPA	TION	16b, KIND OF B	USINESS/INDUS	TRY
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)	nost or working			
₩ W	12		UNDERWR	ITER		INSUR	ANCE	
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N	AME (First, Middle, Maide	n Sumame)	
핆	Daniel	McGrath				Johanna M	4 4	
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or To		
	H. GEORGE SCHWEI'	<u>rzer</u>				. WASHING	-	
	1 Burial 2 Cremation 3 Res	noval from Stata	20b. PLACE AND DATE cemetery, crematory or o			OATE 20c. L		
	4 Donation 5 Other (Specify) GATE OF HEAVEN CEMETERY 3/19 SILVER SPRING, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY							
	FRANCIS J. COLLINS FUNERAL HOME, INC.							
	Limoth	y D. Can	stell	500 U	NIVERSIT	Y BLVD., W.	SIL.SI	PR.,MD.20901
	23. PART i. Enter the diseases, or shock, or heart failura	domplications that can List only one cause of	used the death. Do i on each line.	not enter the n	ode of dying, su	ch as cardiac or res	piratory erres	t, Approximata interval Between
1 [IMMEDIATE CAUSE (Final disease or condition	Λ	A :					Onset and Death
	resulting in death)	· Hrih	y huca					0045
_		DUE TO (OR	y Main as a consequence of expellente	7: 1	Olace.			1000
§	Sequentially list conditiona,	DUE TO (OR	AS A CONSEQUENCE O	FI:	Curry,			9000
M	If any, leading to immediate cause. Enter UNDERLYING			·				į /
Ē	CAUSE (Disease or injury that initiated events	DUE TO (OR	AS A CONSEQUENCE O	F):				
CERTIFICATION	resulting in death) LAST	d						ļ
	PART II. Other significant condition	na contributing to dea	th but not resulting	in the underly	ng cause given ir	Part I. 24a, WAS A	N ALTHOREY	245 MEDI MITOROV ENIONIOS
CAL	jenle Den	calet	or but not reading	in the dilutity	ilg cause given ii		PRMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
MEDI	Julia Cagr					1 TYES	2 140	OF DEATH?
						- 1		1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	T		26.	PLACE OF DEATH (C	hack only one)		
S	EXAMINER?	HOSPITAL:	Outpatient 3 🗆 DOA	QTHER:		8 Other (Specify)		
`	27. MANNER OF DEATH	28a. DATE OF INJU	JRY 28b. TIM	E OF 28c I	IJURY AT	28d. DEŞCRIBE HOW	INJURY OCCUP	REO
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye	in.		ORK? YES 2 NO			
0 8	3 Suicide 6 Could not be	28s. PLACE OF INJ	JURY — Al home, farm,	street, factory, of	Ice	281. LOCATION (Street		Rural Route Number,
Щ	4 Homicide determined	building, etc. (Specify)			City or Town, State)	
COMPLET	29a. CERTIFIER Check only	SICIAN: To the best of my k	nowledge, death occurr	ed at the time, de	te and place, and du	e to the cause(a) and m	enner as stated	
W								ause(s) and menner as stated.
Ξ O	295 SKINGTHIE AND THE OF CONTINH	1			29c. LICENSE NU			IGNED (Month, Day, Year)
m	111 N. 11/1/	/			Naa.	n (.	1 2	1 40 10 -
	VOXA IVIVIVA						/	
TO E	30. HAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF	F DEATH (ITEM 27) (Type	, Print)	1000		1	17/12
	30. HAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF	F DEATH (ITEM 27) (Type	Print)	to Dr.	Creent	eti	20770
	30. MAME AND ADDRESS OF PERSON W Sch (1) 31. DATE FILED (Morith, Day, Year) MAR 19 93	HO COMPLETEO CAUSE OF	F DEATH (ITEM 27) (Type FSO CYCL) SIGNATURE draw-Rendall	. Print) IWzey (the Dr.	breent	eth	20770



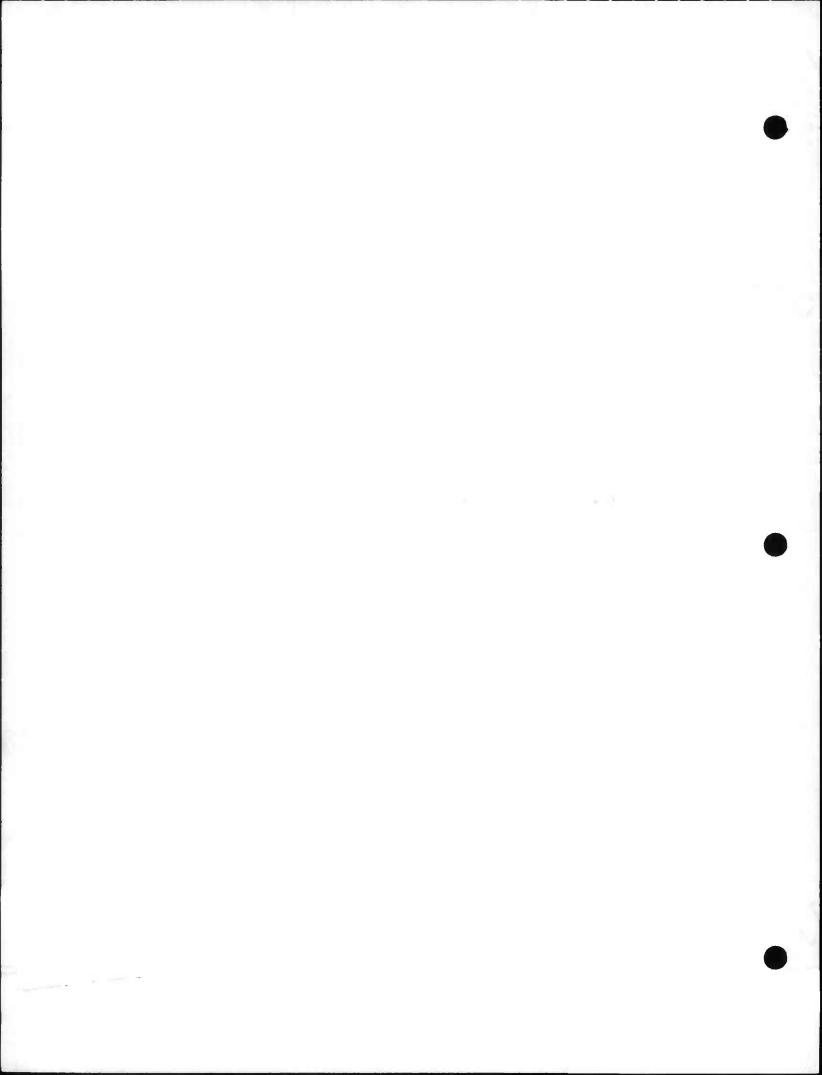
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BALTIMORE, MARYLAND 21215-0020

1 - FOR STATE REGISTRAR

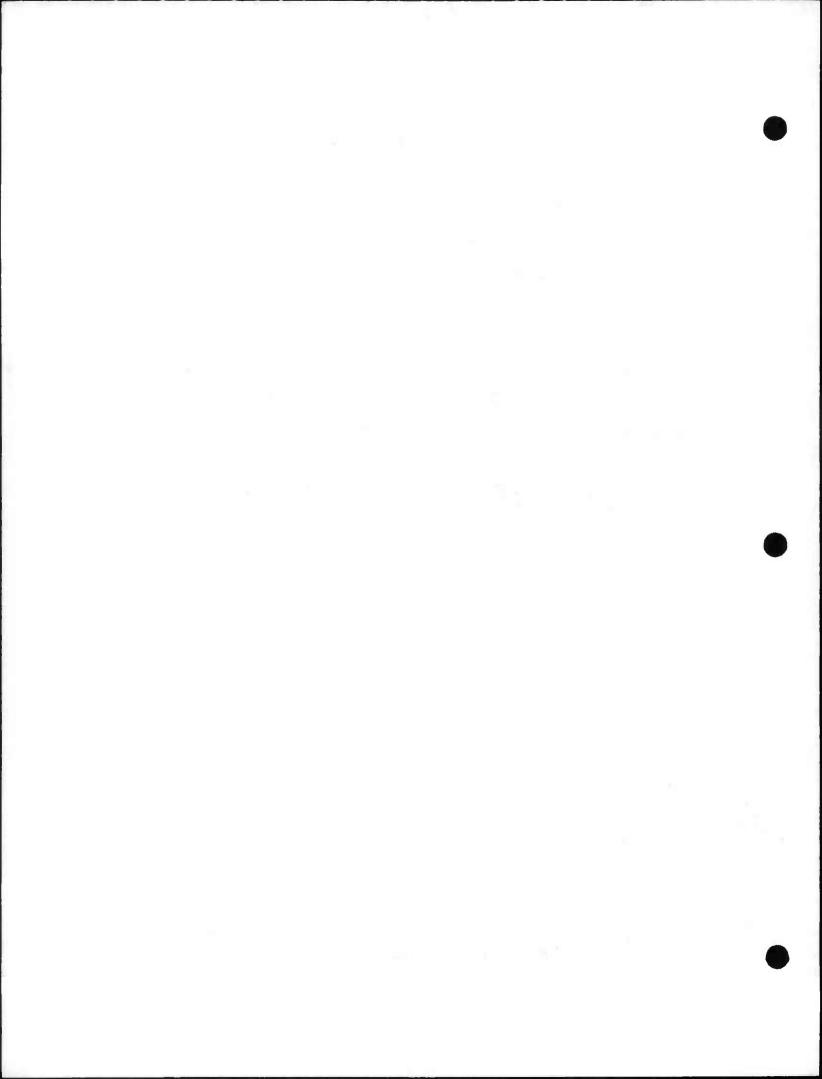
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CERTIF	ICATE O	F DEATH	REG. N	0.		
	1. DECEDENT'S MANIE (FIRST, AROURS Last) M	lay Belle Me	tcalfe			2. DATE OF DEATH	DAY /3	9EAR	3. TIME OF DEATH
	The second of the second secon	The second second	In yrs. last birthday) 9 yrs.	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) May 9,	1913	Count	IPLACE (State or Foreign ny) Itimore, MD
OR	90. FACILITY NAME (If not institution, give stress Suburban Hospital			Beth	or Location of De		9c. COU	NTY OF D	
5	RESIDENCE OF DECEDENT								
. DIRECTOR		gomery	7.7	tomac					10d. INSIDE CITY VIMITS? 1 YES 2 NG
FUNERAL	100. STREET AND NUMBER 10250 Democracy I				20854		US		WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	ed 2 Merried FORCES? 1 YES 2 NO			ECENDENT OF HISPAN specify Cuban, Mexica ES 2 (X NO Specify	n, Puerto Rican, etc.)	fes or No—	14. RACI Black Spec	E — American Indian, k, White, etc. #y: White
COMPLETED	15, DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	mpleted) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of w life. Do NOT us	vork done during	TION most of working	16b. KIND OF E	USINESS/IND	USTRY	
å <u>₹</u>	12		Lega	1 Secre	etary	L	w		
	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maid	en Surname)		
BE	Percy Lamb Farson				Clara H	Edna Sulta	an		
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	t and Number or Rural I	Route Number, City or 1	own, State, Zip	Code)	
2 -	Richard T. Kilby		10250	Democ	cacy La.,	Potomac	, MD	2085	54
<u> </u>	20e. METHOD OF DISPOSITION 1 [XBurlai 2] Cremation 3] Remove		PLACE AND DATE O		Name of	OATE 20c.	LOCATION —	City or To	own, State
Ē	4 Donation 5 Other (Specify)	P	arklawn	Memoria		13/13	Rockvi	11e,	_MD
examiner must be notified at once. TO BE COM	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE /			ano address of factor of Gawler		Γπο		
	michael:	2. Male	5~		Wisconsin			ton	DC 20016
event, the medical	23. PART I. Enter the diseases, or conshock, or heart failure. Lie IMMEDIATE CAUSE (Final disease or condition resulting in death)	it only one cause on e	the death. Do nach line.	ot enter the r	rode of dying, such	h as cardiac or rec	piratory arr	eat,	Approximata Interval Between Onset and Death Sudden
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	CHYONIC DUE TO OR AS A	CONSEQUENCE OF	TIVE	LUNG (Disease			109rs
5 11	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEDUENCE OF	7:					
	PART II. Other significant conditions	contributing to death be	ut not resulting i	n the underly	Ing cause given in		AN AUTOPSY	24b	. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL	Con	Gestine	Hegr-	T FA	: lyre	1 YES	ORMED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL			90	PLACE OF DEATH (Chi	not only and			
SICIAN	EXAMINER?	IOSPITAL:	etient 3 Doe	OTHER:	15.7				
H K	27. MANNER OF OEATH	28s. DATE OF INJURY	28b. TIM		NJURY AT	6 ☐ Other (Specify) 28d. OESCRIBE HON	V INJESTRY OCC	TIREO	
	1 Natural 5 Pending	(Month, Day, Year)	INJ	URY	WORK? YES 2 ND				
	2 Accident Investigation 3 Suicide a Could not be determined	28e. PLACE DF INJURY building, stc. (Spec	— At home, farm, s	street, factory, of	flea	261. LOCATION (Stree City or Town, Sta	et and Number te)	or Rural F	Route Number,
BE COMPLETED	29a, CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA (Check only one) 2 MEDICAL EXAMINER:	N: To the best of my knowl							i) and manner as stated.
N N	296. SIGNATURE AND TITLE OF CERTIFIER	,		-	29c. LICENSE NUM				(Month, Day, Year)
TO BE	Herbet 1	arenta	um N7		4D D-	13381	> 5	3/15	193
F	30. NAME AND ADDRESS OF PERSON WHO O	TANCH DAY			ONIN AINO	ve Cleus	Chas	o U	1 20815
	31. DATE FILED (Month, Day, Year) MAR 19 '03	32. REGISTRAR'S SIGNA		2 426	- 1 - 1 - 1 - 1 - 1 - 1	- ALV	-10-13	7-10	4 05 475



JE VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	SICIAN: The law requires that the death certificate he executed within 24 nouns after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending projection and completely fined in by the function directing projection and completely fined in by the function directing projection of the project	or removal.	medical axaminer must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITE, OF ATTEINING PHYSICIAN: The law requires that the death certificate he elecuted within 24 h	YTO THE FUNERAL QUECTURE, was this certificate has been signed by the attending physician and complexely files	be see within a second with the State Dept. Of realth and Merital Hyglen prior to sarin, cremendal, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

							93	08872
	1 - FOR STATE REGISTRAR	STATE OF MARY		MENT OF HEAL CATE OF DE		ENTAL HYGIEN REG. NO.	E	
1	1. DECEDENT'S NAME (First, Middle, Last)	E. N	1C Enoi	0.10	2	DATE OF DEATH	Y. 6	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE				DATE OF BIRTH		I. BIRTHPLACE (State or Foreign
	217-52-5766		7.4 YRS.	ONTHS DAYS HOU		(Month, Day, Year) 4-10-18		Illinois
TOR	9a. FACILITY NAME (If not institution, give st SOUTHERN ARY RESIDENCE OF DECEDENT	LAND HOSE	itAL (2 CINTO	N, MC	9.		Y OF DEATH
DIRECTOR	Md. Princ	ce George'		itland				10d. INSIDE CITY LIMITS? 1 YES 2 NO
1AL	10o. STREET AND NUMBER			101. ZIP	CODE		10g. CITIZE	EN OF WHAT COUNTRY?
FUNERAL	2521 Ewing Av	enue, Apt.		L 10 1000 1000 1000	20746			ited States
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2 XNO	13. WAS DECENDE It yes, specify (1 YES 2 X	Cuban, Maxican, F	ORIGIN? (Specify Yea Puerlo Rican, etc.)	or No— 1	4. RACE — American Indian, Black, Whita, atc. Specify: White
ם	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S US	k done during most of w	rorking	16b. KIND OF BUS	INESS/INDU	STRY
COMPLET	Elementary/Secondary (0-t2)	College (1-4 or 5+)	Homema			Own H	ome	
CON	17. FATNER'S NAME (First, Middle, Last)					(First, Middle, Maiden		
8	James Wesley 190. INFORMANT'S NAME (Type/Print)	Brooks	10h MAILING AT	DDRESS (Street and Nu.		3. Foust	0	
5	Paul McFarland			luebird				9.1
	20a. METNOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Ramo	wal from State 20	b. PLACE AND DATE OF	DISPOSITION (Nama of	3-10-9	SATE 20c. LO	ATION — CI	y or Town, Stata
	21. SIGNATURE OF TUNERAL BERVICE LIG	ENSEE	rlington	22. NAME AND AD	DRESS OF FACILI	Mee Fur	neral	Home Inc
	Derot 15	3		6633 O	ra Ale:	xander 1	erry	Road
	23. PAFFI I. Enter the diseases, or cahock, or heart failure. I. IMMEDIATE CAUSE (Final disease or condition resulting in death)	refracto	VV \	entar tha mode of	dying, such a	s cardiac or reapi	atory arres	Approximate interval Between Onset and Death
RTIFICATION	DUE TO (OR AS A CONSEQUENCE OF):							
ш	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF):					
S	CAUSE (Disease or Injury that initiated events resulting in death) LAST			the underlying cau	se given in Par	rt i. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS
S	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions Neuman	a contributing to death I	out not resulting in			rt i. 24a. WAS AN . PERFOR	WED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF OEATN?
S	PART II. Other significant conditions PART II. Other significant conditions ACLIFE GAS		out not resulting in	emorrh	se given in Par	PERFOR	WED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
S	PART II. Other significant conditions PART II. Other sig	contributing to death in the internal techniques	out not resulting in	en orrh		PERFOR	WED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF OEATN?
S	PART II. Other significant conditions PART II. Other sig	contributing to death I	petient 3 DOA	26. PLACE O	OF DEATN (Check	only one)	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATN? 1 PYES 2 NO
PHYSICIAN: MEDICAL CE	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions PRUMM A A(L) te GAS CNONC 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	e contributing to death in the internal techniques	out not resulting in	26. PLACE C	OF DEATN (Check Residence 8	PERFOR 1 X YES 2	MED?	AMAILABLE PRIOR TO COMPLETION DF CAUSE DF OEATN? 1 PYES 2 NO
BY PHYSICIAN: MEDICAL CE	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions PREMIMINA ACLIFE GAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	HOSPITAL: Month, Day, Year)	petient 3 DOA 4	26. PLACE O THER: Nursing Nome 5 [F	OF DEATN (Check Residence 8 T 28	only one)	MED?	AMAILABLE PRIOR TO COMPLETION DF CAUSE DF OEATN? 1 PYES 2 NO
BY PHYSICIAN: MEDICAL CE	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions PRUMMIA CLUB GG 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only) CERTIFIER 1 CERTIFYING PNYSIC	HOSPITAL: Results Res	patient 3 DOA 4 20b. TIME C	26. PLACE OF THER: Nursing Nome 5 WORK? W 26c. INJURY A WORK? I VES et, factory, office	P DEATN (Check Residence 8 T 28 2 NO 28	only one) Other (Specify) It. LOCATION (Street a City or Town, State)	MED? NO NO NO NO NO NO NO NO NO N	AMAILABLE PRIOR TO COMPLETION DF CAUSE DF OEATN? 1 OFYES 2 INO RED Rural Route Number,
BY PHYSICIAN: MEDICAL CE	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions PRUMMIA CLUB GG 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only) CERTIFIER 1 CERTIFYING PNYSIC	HOSPITAL: 1 Ningtlent 2 ER/Out 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spe	patient 3 DOA 4 20b. TIME C	26. PLACE OF THER: Nursing Nome 5 Sec. INJURY A WORK? M 1 YES et, factory, office In the time, data and p	PRESIDENT (Check Residence 8 2 2 No 28	Only one) Other (Specify) Id. LOCATION (Street a City or Town, State) the cause(a) and man e, data and place, and R	JURY OCCUI	AMAILABLE PRIOR TO COMPLETION DE CAUSE DE OEATN? 1 OFYES 2 INO RED Rural Route Number, cause(a) and manner as stated. HIGNEO (Month, Day, Year)
PHYSICIAN: MEDICAL CE	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions PART II. Other significant conditions PART II. Other significant conditions PART II. Other significant conditions PART II. Other significant conditions PART II. Other significant conditions PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER 25. WAS CASE REFERRED TO MEDICAL EXAMINER 26. Significant Significant conditions PART II. Other significant conditions PART II. Other	HOSPITAL: 1 R Inpetient 2 ER/Out 28e. PLACE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, stc. (Spe	patient 3 DOA 4 28b. TIME C INJUR 7 — At home, tarm, stre city)	26. PLACE C THER: Nursing Nome 5 F WORK? M 28c. INJURY A WORK? 1 YES et, factory, office It the time, data and p In my opinion, death o	P DEATN (Check Residence 8 T 28 2 NO 28 lace, and due to to coursed at the time	Only one) Other (Specify) Id. LOCATION (Street a City or Town, State) the cause(a) and man e, data and place, and R	JURY OCCUI	AMALABLE PRIOR TO COMPLETION DF CAUSE DF OEATN? 1 PYES 2 NO RED Rural Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL CE	CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions PART II. Other significant conditions PART II. Other significant conditions PART II. Other significant conditions ACLY CONDITION 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	HOSPITAL: Note Complete Co	patient 3 DOA 4 28b. TIME CITY At home, tarm, strectly on and/or investigation, is	28. PLACE C THER: Nursing Nome 5 North Nursing Nome 5 North Nursing Nome 5 North Nursing Nome 5 North Nursing Nome 5 North Nursing Nome 5 North Nursing Nome 5 North Nursing Nome 5 North Nursing Nome 5 North Nursing North Nursing N	F DEATN (Check Residence 8 T 28 2 NO 28 lace, and due to to coursed at the time	only one) Other (Specify) Id. DESCRIBE HOW IN II. LOCATION (Street a City or Town, State)	JURY OCCUI	AMILABLE PRIOR TO COMPLETION DF CAUSE OF GEATIN? 1 OF YES 2 NO RED Rural Route Number, cause(a) and manner as stated. HIGNEO (Month, Day, Year) Arch S 1993



BALTIMORE, MARYLAND 21203-3146

TO THE BUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be abded within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

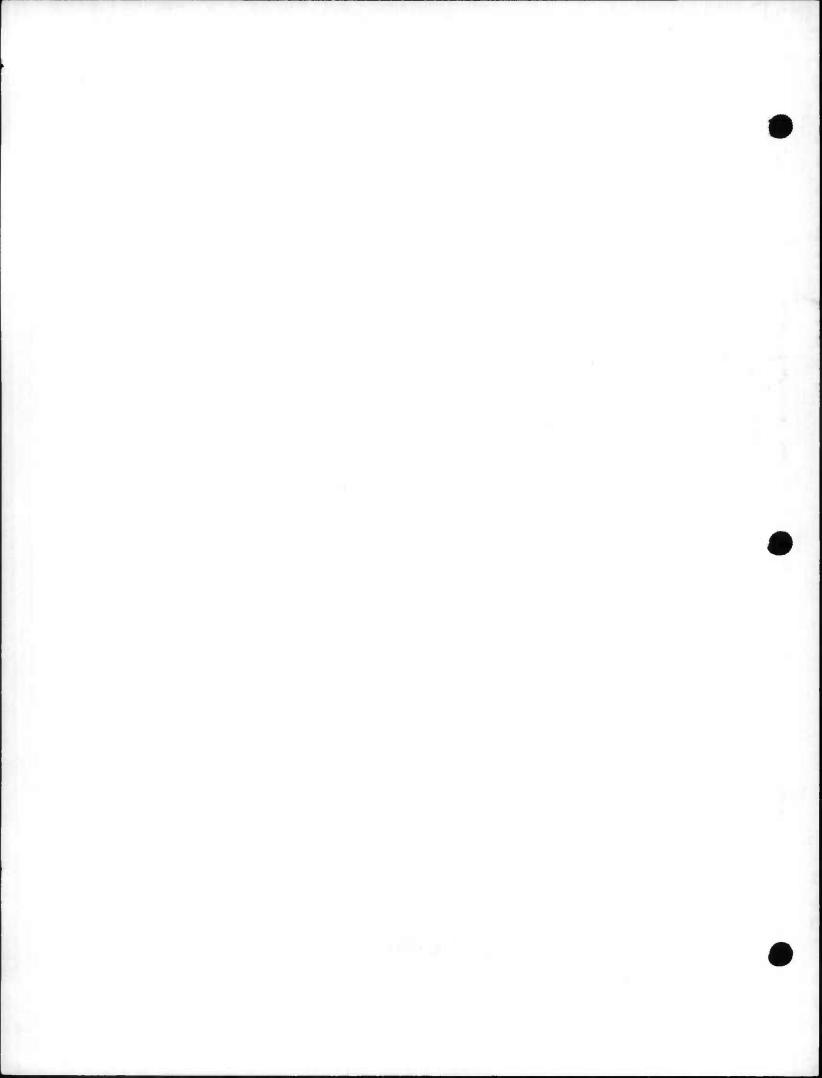
MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a frous after death. Page 6 may be retained by the hospital or attending physician.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		T OF HEALTH AND E OF DEATH	MENTAL HYGIEN		08873
	1. DECEDENT'S NAME (First, Middle, Leat) o	Taynisha F	McKei V	ver	2. DATE OF DEATH DO NOTH	- 93	3. TIME OF DEATH 3.45 M
		6. AGE (In yrs. Is	YRS. MONTHS	R 1 YEAR SF UNDER 24 HRS. BAYS HOURS MIN. 1	7. DATE OF BIRTH (Month, Day, Year) 3-1-93	M	SIRTHPLACE (State of Foreign Country)
OR	9e. FACILITY NAME (If not institution, give street Malcolm Grow Me RESIDENCE OF DECEDENT			amp Spring		9c. COUNTY	e George's
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY, TOWN	111111111111111111111111111111111111111			10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	ce George's	I Fores	tville 101. ZIP CODE		10g. CITIZEN	1 ☐ YES 2 ☒ NO OF WHAT COUNTRY?
FUNERAL	6507 Hillman I			20747		US	
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. WAS DECEDENT EVER IN U.S. A FORCES? 1 ☐ YES ♣☐ IF YES, GIVE WAR OR DATES	RMED 13.	WAS DECENDENT OF HISPA: If yee, specify Cuben, Mexico 1 YES 2 NO Specif	an, Puerto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify: Black
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12)	College (1-4 or 5+)		during most of working	16b. KIND OF BU	SINESS/INDUST	RY
JMP	17. FATHER'S NAME (First, Middle, Last)	No	n-Appli		AME (First, Middle, Malder	Sumamal	
BE C	Ronald T. McKe	iver			lique Ki		
10 8	19a. INFORMANT'S NAME (Type/Print) Ronald McKeive			Same as 10		vn, State, Zip Cod	(0)
	20a. METHOD OF DISPOSITION 1 □ Buriel 2 ☒ Cremation 3 □ Remov	20b. PLACI	OF DISPOSITION (A	lame of corretery, crematory or		DCATION — City	or Town, State
	4 Donation 6 Other (Specify)	I	ee Crem	natory	C1	inton	, Md .
	21. SIGNATURE OF TUHERAL SERVICE LICES	YSEE		633 Old Al			
	23. PART I. Enter the diseases, or co	mplications that caused the d st.only one cause on each lin	eath. Do not ente	r the mode of dying, aud	ch as cerdiec or resp	oiratory arrest,	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Du motwiele	7(5×	In In			Onset and Deeth
_		DUE TO (OR AS A CONS	FOUNCE OF):				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONS	EQUENCE OF):			,	
ERTIF	that initiated events resulting in death) LAST	DUE TO (OR AS A CONS	EQUENCE OF):				
	PART II. Other algnificant conditions	contributing to death but not	resulting in the u	inderlying cause given in	Part I. 24a. WAS AI	N AUTOPSY PRMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL					1 YES		COMPLETION OF CAUSE OF DEATH?
	· -				-		1 🗌 YES 2 🗍 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PLACE OF DEATH (C	heck only one)		
IXSI		28a. DATE OF INJURY		ursing Home 5 - Residence		W. H. W. O. O. O. O. O. O. O. O. O. O. O. O. O.	
ву РН	1 Netural 6 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. DEŞCRIBE HOW	INJURY OCCUR	ED
8	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At I building, etc. (Specify)	nome, farm, street, fa	ctory, office	28f. LOCATION (Street City or Town, State	and Number or F	Bural Route Number,
COMPLET	(Oracon Oray	AN: To the best of my knowledge, o					ause(s) and manner as stated.
BE CC	296. SUSPECTURE AND TITLE OF CONTROLS	maux MV	1	29c LICENSE NU 212	MBER		GNED (Month, Day, Year)
2	When the source of severe	COMPLETED PAUSE OF DEATH AT					- / /

DEATH (ITEM 27) (Typo, Print)

Isha Davidson-Randall

MAR 0 0 199



020	physician.
21215-0020	age 6 may be retained by the hospital or attending ph
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ND 2	hospital
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MARYLAND	retained
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TIMORE.	0
BALTI	death.
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page 5 should be detached for

filled in by the funeral director,

in and completely filled in by the to burial, cremation, or removal,

use as the burial-transit permit. Pages 1, 2, 3 should

nours after death.

,09	d within	mpletely	, cremai	went,
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HID SELAN OR STENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE MERIAL OF CTOR: After this certificate has been signed by the attending physician and completely	to burial	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event,
ô	e De	siclan	rior 1	trau
O. B	ertificat	ing phy	giene p	other
٦.	ath c	Tend	al H)	9
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OR	that	ed by	th and	any
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATN 2. DATE OF DEATH YEAR 93 Mohr IVY ucy Mar. 2:00 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH
JULY 6, 1902 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 90 England 130-16-4551 1 M 2 X F YRS. 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Southern Maryland DIRECTOR linton Hospital nce Jeorge RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Flordia Pinellas St. Petersburg 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3900 33709 53rd Street N. U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuban, Mexican, Pu 1 ☐ YES ②XX NO Specify: IF YES, GIVE WAR OR DATES ВУ SpecMy: white 3XXWidowed 4 ☐ Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEOENT'S EDUCATION (Specify only highest grade complete 16b. KINO OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Home maker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) notified at Alfred Cox BE Frances Deveraux 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John F. Mohr Halleck St. District Heights, MD 20747 pe 20a. METHOD OF DISPOSITION
1 Buriel 2 Decremention 3 Removal for 20b. PLACE AND DATE OF DISPOSITION / Name of 20c. LOCATION — City or Town, State DATE must cemetery, crematory or other place) Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 3/8/93 Alexandria, VA examiner 1. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 4308 Suitland Rd. Marshall's Funeral Home, Inc. Suitland, MD20746 medical 23. PART I. Enter the dimeses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between IMMEDIATE CAUSE (Pinal Onset and Death the Sepses disease or condition resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate CAUSE Enter UNDERLYING CAUSE (Disease or injury injury, or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAR ARLE PRIOR TO shows any COMPLETION OF CAUSE 1 TES 2 NO 1 YES 2 NO has be Dept. | 23 sl 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) Hem EXAMINER? HOSPITAL: OTHER: 1 Inpetient 2 ER/Outpetient 3 DOA te 5 🗆 Residence 8 🗆 Other (Specify) 0 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Netural 5 Pending BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 🗌 Homicide 29a. CERTIFIER CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. 2 __MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner se stated. 29b. SIGNATURE AND /TITLE OF CERTIFIES 29d. DATE SIGNED (Month, Day, Year) BE 6 3 3 8 9 scoula 52



2

30. NAME AMOUND OF PERSON WI

MAR 0 9 1993

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

In Day Day doon Randale

131 Kscatawai

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1												
1 10	1. DECEDENT'S NAME (First, Middle, Last)		ER, SR.				2	DATE OF DEATH	v	YEAR	3. TIME OF DEATH	
	CHESTER W				N	March 7, 1993			8:45 P	M		
	4. SOCIAL SECURITY NUMBER	MGE (In yrs. lest birtho	<i>"</i>	NOER 1 YEAR	DER 1 YEAR IF UNDER 24 HRS.		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign			
	187-24-3807	62 YR	S. MON	THE DAYS	HOURS	MIN.	Nov. 17, 1930 Some			erset, PA		
- 3	9a. FACILITY NAME (If not institution, give at	reet and number)	-	9b.	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH						_	
œ	7504 Terra Alta Court				anhan							
15	RESIDENCE OF DECEDENT				Jalillali	.1			Prince George's			
DIRECTOR	10a. STATE 10b. COUNTY		10c.	CITY, TO	WN OR LOC	ATION			10d, INSIDE CITY			
분	Maryland Princ	vatt	svill			4.59						
7	10e. STREET AND NUMBER	yacc	101. ZIP CODE					350,05	1 XES 2 NO	_		
RA	/702 H. 11. G.			20781				THAT COUNTRY?				
BY FUNERAL	4703 Hamilton Str						U.S.A.					
윤	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVEN FORCES? 1 X 1		13. WAS DECENDENT OF HISPANIC Of If yes, specify Cuban, Mexican, Po				ORIGIN? (Specify Yes Puerto Rican, etc.)	or No-	14. RACE Black	- American Indian, t, White, etc.	
≥	3 Widowed 4 Divorced	IF YES, GIVE WAR O	R DATES			S 2 🛛 NO		, ,		Speci	fy:	
		Korean								White		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	:ATION completed)	16a. DECEDEN (Give kind	f of work o	done during n	ION nost of working		16b. KIND OF BUS	INESS/IN	DUSTRY		
Ÿ.	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NO	OT use retir	red.) Coc	rdinat	or	1				
P P	12th Grade		Product	ion M				Manui	acti	ırıng	5	
Ş I	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER	R'S NAME	(First, Middle, Maiden	Sumame)			
	Leo F. Mi	ller				Dora	1	м.	Snyde	er		
BE	19a. INFORMANT'S NAME (Type/Print)		19b, MAJ	JNG ADD	RESS (Street	and Number or	Rural Rou	te Number, City or Town	State 7i	Code)	. .	
2	Elaine R. Miller							lyattsvil			20781	
	20a. METHOD OF DISPOSITION						, , ,					_
3	1 ₺ Burial 2 ☐ Cremation 3 ☐ Remo	wel from State	20b. PLACE AND DA	or other pi	SPOSITION (F la <u>c</u> a)	vame of		DATE 20c. LOC			City or Town, State	
	4 Donation 5 Other (Specify)	$-\Delta$	Schellsb	urg					ells	ourg,	rg, Pennsylvan	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	_/		Exame	AND ADDRESS	OF FACILI	Sons Fur		l Uon	D A	
	1/1/h 4 00 0	a Afrit	11-									
	22 BADT I Saturday diagram	1 400	400		4/39	Baltim	nore	Ave., Hyai	tsv	гтте,	MD 20781	
	23. PART i. Enter the diseases, or c shock, or heart fallure. I	iat only one cause t	med the death. L	o not e	nter the m	ode of dying	, such a	s cardiac or respin	atory an	reat,	Approximate Interval Between	
- 1	IMMEDIATE CAUSE (Final	10. 7	3 /		1		0				Onset and Dec	
- 1	disease or condition resulting in death)	1/10/16	SOAL		1.11	MY (AA	UPPL			144x	. 1
- 1	resorting in death)	DUE TO OR	AS A CONSEQUENC	E OF):	6	at 1	11.				17700	-
The state of the s						V					1 *	
7	Sequentially list conditions,										+	-
NO		If any, leading to immediate										
ATION	if any, leading to immediate cause. Enter UNDERLYING		CAUSE (Disease or injury									
FICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR /	AS A CONSEQUENC	E OF):								-
RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR A	AS A CONSEQUENC	E OF):								
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR .	AS A CONSEQUENC	E OF)				.,,				
A CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	i.	**************************************	1.51.67	e underlyi	ng cause give	en in Pa			24b.	WERE ALITOPSY FINDING	as
	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	i.	**************************************	1.51.67	e underlyii	ng cause give	en in Pa	PERFOR	MED?	24b.	MAILABLE PRIOR TO	
	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	i.	**************************************	1.51.67	e underlyii	ng cause giv	en in Par		MED?	246.	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
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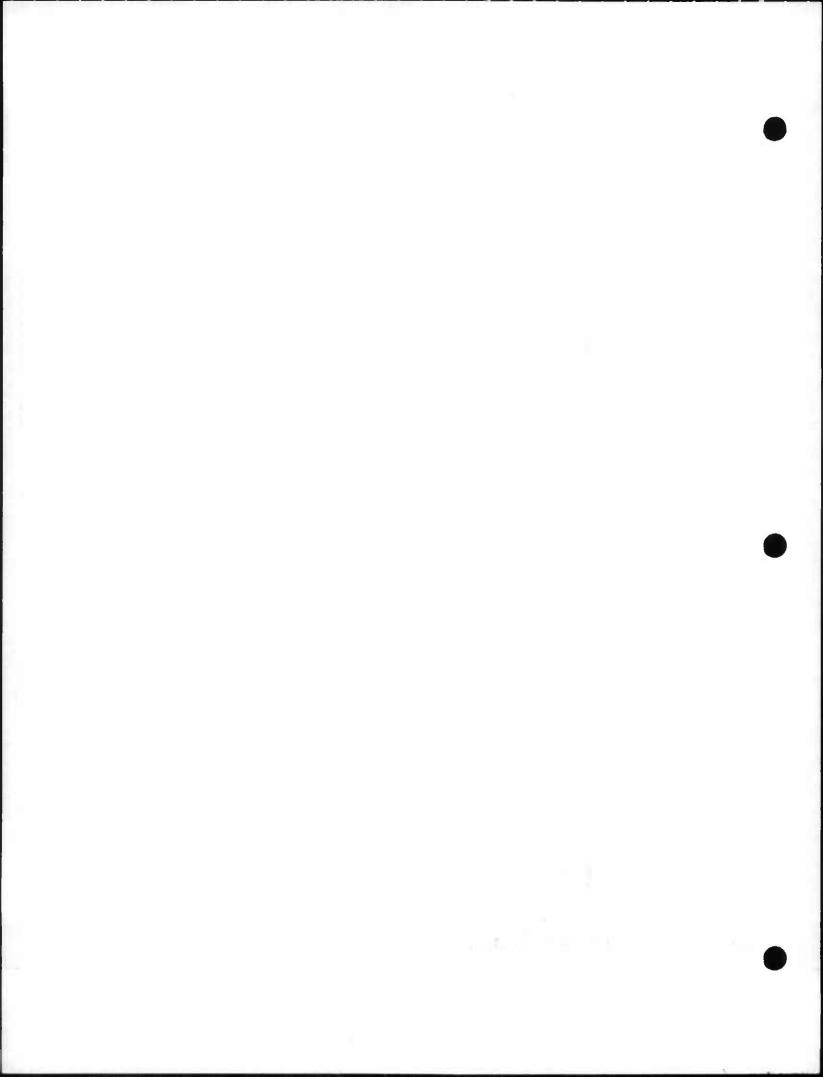
THE HOSTIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

The HOSTIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Merial Hygiene prior to burial, cremation, or removal.

INPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-16 Rev 1/89



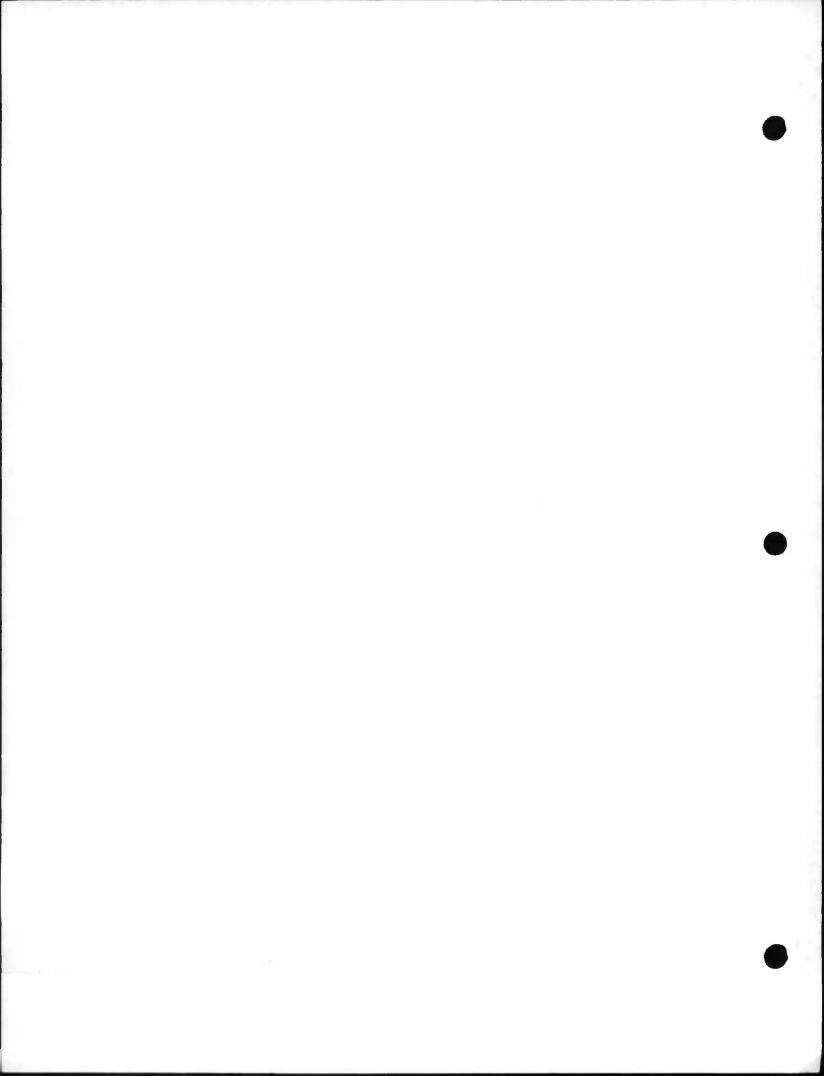
		FOR	STATE OF MARY	IAND / D	EDAD	TIACNT (ve h	PAITU AND	MENTAL	UVOJEN		0	8876
		1 - STATE REGISTRAR	SIMIL OF MAIL					DEATH	MERIAL	REG. NO			
		1. DECEDENT'S NAME (First, Middle, Last) EARL MITCHELL							2, DATE O	F DEATH	AY	YEAR	3. TIME OF DEATH
,		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs, lest b	(IF UNDER 1 1	e		03		80	93	2:10 a ^m
	- 8	230-28-0499	15XM 2 □ F 64		YRS.		AYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE Of (Month), 2/13	Day, Year)		Count	
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2.3	E E	Greater Laurel-Be	eltsville Ho	<u>spita</u>	1	Laur	e1				Pri	nce (George's
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retained by the hospital or attending physician. 5 should be detached for use as the burial-tran	2	19e. INFORMANT'S NAME (Type/Print)						nd Number or Rura				ip Code)	
ay be		Sandra L. Warder		b. PLACE AND				. Lothi		_		T	
rector. p		1 Buriel 2 Cremation 3 Remo	wal from State	metery, crema Metrot	tory or o	ther plece)	ren	natory	3/9/9	20c. LC	xand.	ria.	Va.
death. Page 6 ma e funeral director. i.		21. SIGNATURE OF FUNERAL SERVICE LIC											
the fune the fune oval.		Be f. Kd	George P. Kalas Funeral Home 160 Oxon Hill Rd. Oxon Hill, Md. 20745										
W SE		23 PART/. Enter the diseases, or c	complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate										
24 hours filled in I on, or re		MMEDIATE CAUSE /Final											
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death e atter fental	Ö	PART II Other significant and distri).						- 1				
ATTENDING PHYSICIAN: The law requires that the death SCOR, After this certificate has been signed by the attention when the State Dept. Of Health and Mental F. 28 in marked, or flow 23 shows any fairty on 28 shows any fairty.	MEDICAL	PART II. Other significent condition:					rlying	ceuse given in	Part I.	PERFO		24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
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has been sign Dept. of Hea									_				1 YES 2 NO
SECIAN: The last certificate has the State Deg	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	MOCRITAL				26. PL	ACE OF DEATH (C	heck only one)				
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NG PHYSIS the this o seth with marked		27. MANNER OF DEATH 1 XNatural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	1	NIT .689	URY	WOF		28d. DEŞC	RIBE HOW	INJURY OC	CURED	
After death		2 Accident Investigation 3 Suicide 6 Could not be	M 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office						281, LOCATION (Street and Number or Rural Pouts Number.				
ATTEN STOR		4 Homicide datermined	building, etc. (Spe	ecify)					City or	Town, Stete)		
8 6 2	PLE		CIAN: To the best of my know	wledge, death	occurr	ed at the time	, date	end place, and du	e to the cause	e(e) and ma	nner as ste	nted,	
THE STATE OF	COMPL	one) 2 MEDICAL EXAMINE	R: On the basis of exemination	on and/or inve	estigatio	n, in my opin	ion, de	eath occured at th	e time, date a	nd place, ar	nd due to t	he cause(e) and manner se stated.
	BE	296. SIGNATURE AND TITLE OF CENTIFIER	744	_				29c. LICENSE NU	MBER		29d. DA	TE SIGNED	(Month, Dey, Year)
223	2	39, NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	FATH STEM *	7) /5	Print ¹	_	J 33	742	_		YY	93
hyproxin 190		Greater	Vamil Be	Ushil	R.	trosp	ih	ne la	uscl	MI	>	, ,	
3		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG										
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BALTIMORE, MARYLAND 21215-0020

VISION OF VITAL RECORDS, P.O. BOX 68760,

Jakis Guidson-Handage

DHMH-16 Rev 1/89



3, TIME OF DEATH

REG. NO.

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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Ulbugh ames - 8 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Fo 1 🖳 M 2 🗌 F 185-20-4842 2-28-1927 New York for use as the bunal-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Fort Washington Medical Center Fort Washington Prince Georges 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD Prince Georges Fort Washington 1 - YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 12921 Asbury Drive 20744 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 \(\) YES 2 \(\) NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 K Merried If yes, specify Cuban, Mexican, Puerto Rican, etc.) BY 1 YES 2 TYNO Specify: 3 Wildowed 4 Divorced Specify: 1950 - 1970 White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondery (0-12) College (1-4 or 5+)
4 years detached Lieutenant Colonel U.S. Air Force 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James S. McCullough 2 notified at BE Helen E. Middlemiss 194. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Alice C. McCullough 12921 Asbury Drive Ft. Washington, Md. 20744 pe 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 206. METHOD OF DISPOSITION

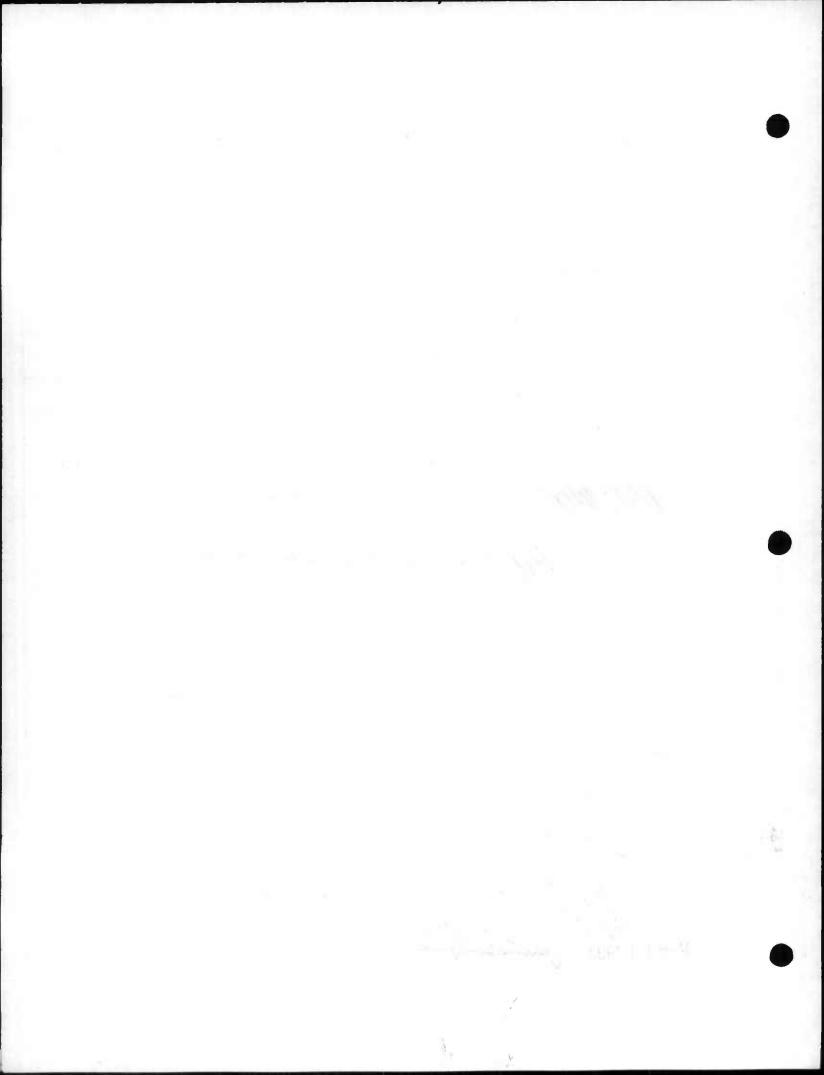
1 Durial 2 Cremetion 3 Removal from State

4 Donation 5 Other (Specify) must funeral director, Arlington Nat'l. Cem. 3-17-93 Arlington, Virginia examiner 22. NAME AND ADDRESS OF FACILITY
George P. Kalas Funeral Home
6160 oxon Hill Rd. Oxon Hill, Md. 20745 ETAL SETVICE LICENSEE and completely filled in by the oburial. cremation, or removal. medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onest and Death the disease or condition en tensure Jarditvis well disease reaulting in death) event. QUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 9 If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury the attending physician Mental Hygiene prior to other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury. PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS by AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any signed the 1 YES 2 100 shows 1 | YE\$ 2 | NO been . PHYSICIAN: has be Dept. 23 25. WAS CASE REPERRED TO MEDICAL EXAMINEN? 26. PLACE OF DEATH (Check only one) certificate h the State 1, or item OTHER: ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA ne 5 🗆 Raeldence 6 🗆 Other (Specify) 27. MANNER OF GEATH 26e. OATE OF INJURY (Month, Day, Year) this cu marked, 28c. INJURY AT WORK? 26b. TIME OF 26d. OEȘCRIBE HOW INJURY OCCUREO 1 Natural 5 Pending Investigation BY 1 YES 2 NO After t 2 Accident 26e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify) 3 Suicide .09 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) TZ hours after of COMPLETED 6 Could not be 4 Homicide 28 IMPORTANT: If item 29e. CERTIFIER
(Check only one)
one)

The Description of the Descripti 2- MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner ee stated. 五年 500 BE 29d. DATE SIGNED (Month, Day, Year) -2123 3-223 5 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Cad15/8 th, Day, Yes 1993 32. RESISTRAR'S SIGNATURE DO

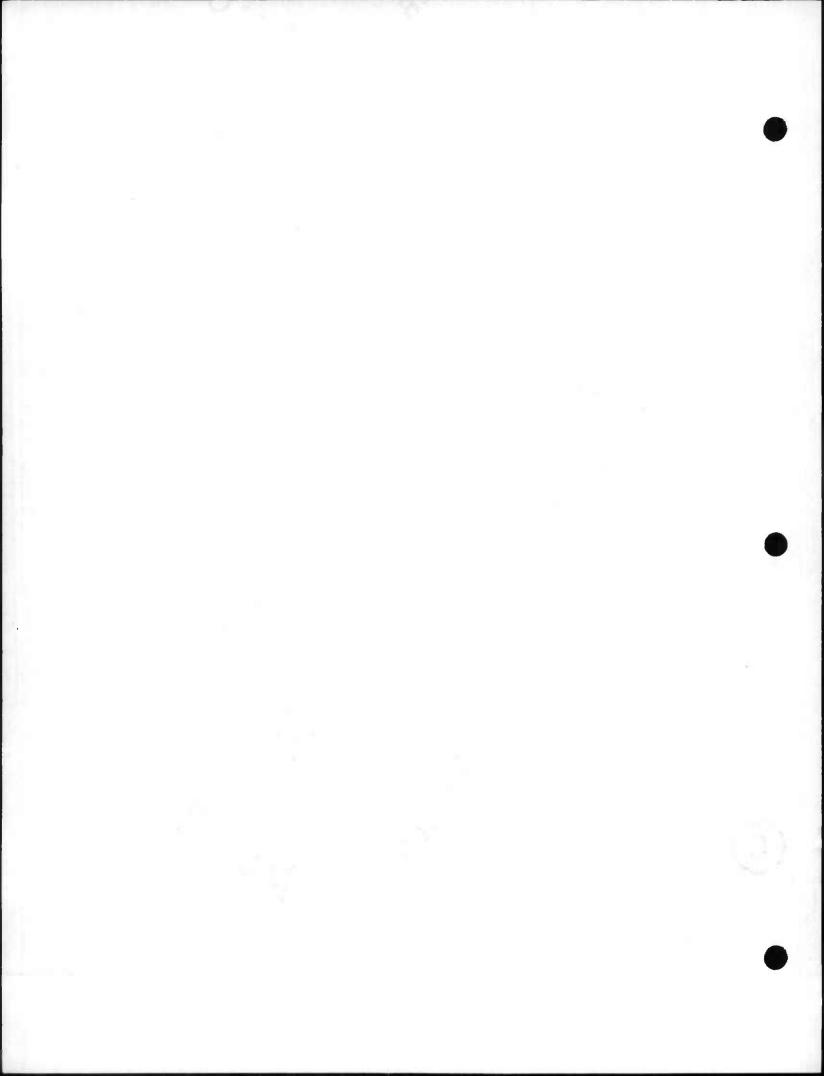
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	EAL CINETICE: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should a second that have State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	or TINDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ENL CIRETICE: After this certificate has been signed by the attending physician and completely filled in by the fine a size better the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	Them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MA			RTMENT				MENTAL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Lest)	Herbert			McKi	11en			2. DATE OF DEATH MONTH March 9,	1993		3. TIME OF DEATH 8:12A M
	4. SOCIAL SECURITY NUMBER 578-10-8101		AGE (In yrs. lest	birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	3/12/16		6. BIRTH	PLACE (State or Foreign hington, D.C
9	Sa. FACILITY NAME (If not institution, give a				9b. CITY,	TOWN O	R LOCATIO	ON OF DE		9c. ÇOU	NTY OF D	
OR	Southern Maryland	l Hospital	Center		Cli	nton				Pri	ince	George's
딦	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION								104 INSIDE CITY			
DIRECTOR	Maryland Charles Waldorf								YES 2 NO			
ERAL	100. STREET AND NUMBER 11300 H Golden Eagle Pl. 20603 USA								WHAT COUNTRY?			
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	VER IN U.S. ARM YES 2 NO OR DATES	J.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No						14. RACI Black Spec	E — American Indian, k, White, atc. White		
윤	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)			USUAL OC				18b. KIND OF BUS	HESS/INC	DUSTRY	
15	Elementary/Secondary (0-12)	College (1-4 or 5+)	Mo. I	Do NOT u	butor			-	Machi		D.	-t. D
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		בוע	SLI I	Duloi	, OII			1 WaSII1 ME (First, Middle, Maiden		n Po	st Paper
Ö	John C. McKille	n							Cornelius		V	
TO BE CON	19s. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADDRESS	(Street an			loute Number, City or Town		,	
F	Lorraine W. McK	illen		sa	me as	ite	em 10)				
	200. METHOD OF DISPOSITION 1											
	21. SIGNATURE OF POMERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745											
	23. BEHT I. Enter the diseases, or	complications that be	sused the dea	th. Do	not enter	the mod	OXON	ng. such	as cardiac or reapi	ratory an	rest.	Approximate
	interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) Acute myocardial infarction/arteriosclerotic DUE TO (OR AS A CONSEQUENCE OF): cardiovascular disease											
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING											
SERTIFI	CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (DR AS A CONSEQUENCE OF):											
CAL	PART II. Other significant condition	s contributing to de	ath but not re	sulting	in the Un	derlying	cause g	iven in f	Part I. 24a. WAS AN PERFOR	MED?	24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDI									_	**		1 TYES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL					20 04 /	CE DE DE	EATH OLD	-111			
SICI	EXAMINER? 1 YES 2 NO	HOSPITAL:	R/Outpatient 3 [DOA	OTHER 4 Num	1:			8 Other (Specify)			
¥	27. MANNER OF DEATH	28s. DATE OF INJ	JURY	28b. TIN	E OF	28c. INJU	RY AT	siderice	28d. DESCRIBE HOW II	JURY OC	CURED	
ВУР	1 Netural 5 Pending 2 Accident Investigation	(Month, Day,	rear)	lev.	JURY M	1 Y	ES 2	NO				
	3 Suicide 8 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								Route Number,			
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSI	CIAN: To the best of my										i) and manner as stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	1	Λ.4					NSE NUM				(Month, Day, Year)
10	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE (OF DEATH (ITEM	27) (Type	, Print)		ע ע			M	larch	9, 1993
	Philip Wisotsky,	M.D. 6188	Oxon H	ill	Rd.	Oxon	Hil	1, M	d. 20745			
	MAR 1 1 1993	32. REGISTRAR'S	SIGNATURE Pandall									



3. TIME OF DEATH

17

REG. NO.

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

В.

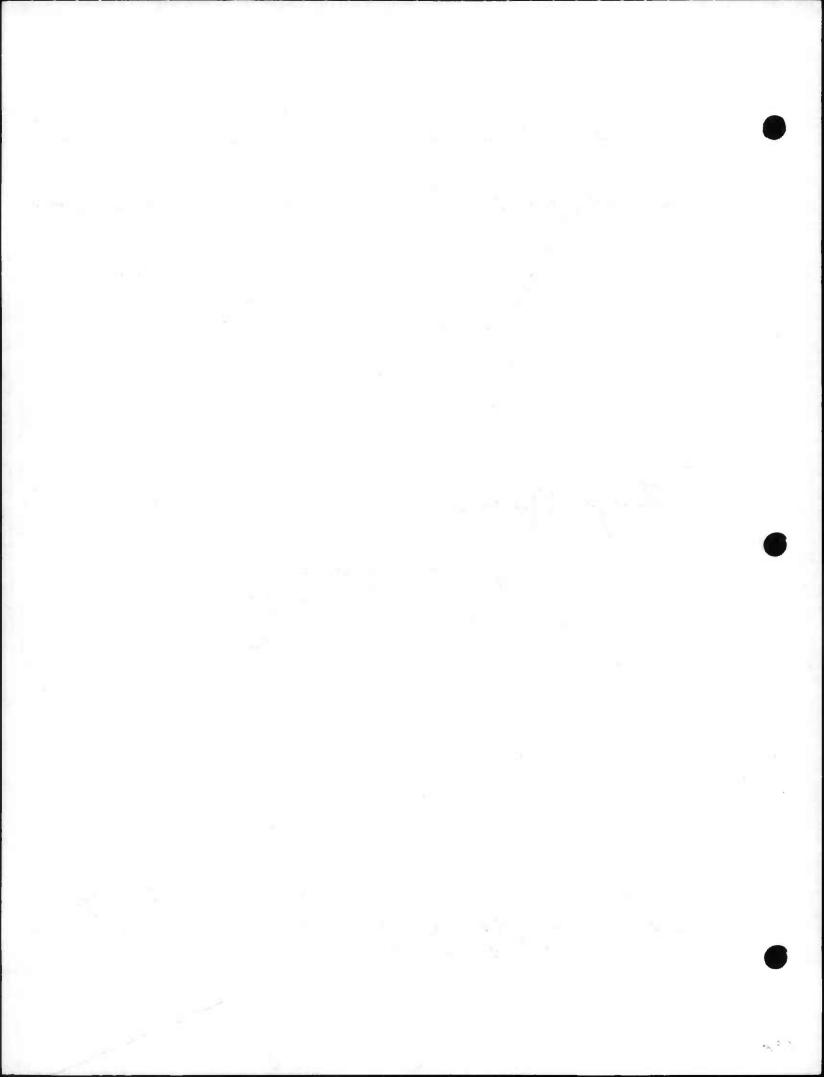
1 -

2	1
DIVISION OF VITAL RECORDS, P.O. BOX 6876	The Party Duvolotant The Party securities show the death and Speed by
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-	18

ENNIE MCDONALD 05 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign April 13 1 🔲 M 2 😿 F 86 240-46-6942 ,1906North Carolina director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR MICHOCA CEDENT RESIDENCE OF DE 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Temple Hills Maryland Prince Georges 1 YES 2 X NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5201 Temple Hill Rd. 20748 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 25 THO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 T NO Specify: BY 3 Wildowed 4 Divorced white COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compl Elementary/Secondary (0-12) College (1-4 or 5+) 4 Nurse Hospital notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname, Charles Cameron Addie Phillips B 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 5201 Temple Hill Rd. Temple Hills, MD 20748 Mary Louise Convers Pe 20a. METHOD OF DISPOSITION
1 😾 Burlal 2 🗆 Cremation 3 🗆 Rai
4 🗆 Donation 8 🗀 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Buffalo-Jonesboro Cemetery8/6/9B Sanford, NC examiner 21. SIGNATURE OF FUNERAL SERVICE LIE n by the funeral or removal. 22, NAME AND ADDRESS OF FACILITY 4308 Suitland Rd. Marshall's Funeral Home, Inc. Suitland, MD20746 rya medical 23. PART I. Enter the disesses, or comfilled in by lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, of heart fallure. List only one cause on each line. Interval Betw ŏ IMMEDIATE CAUSE (Final completely filled rial, cremation, o Onset and Death the disease or condition event, resulting in death) "DUE TO (OR AS A COMPEQUENCE OF): the attending physician and con Mental Hygiene prior to burial, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 0 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? Health and I shows any 1 TES 2 NO OF DEATH? 1 YES 2 NO peen 6 PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h Hem HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 9 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation BY 1 YES 2 NO MOR: After the 2 Accident 28s. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 90 COMPLETED 8 Could not be 4 Homicide 28 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 불북물 Gunlbrett N. Hellon P P.8 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 20748 OLD 4467 32. REGISTRAR'S SIGNATURE
FINE DAVIDSON - Randell

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

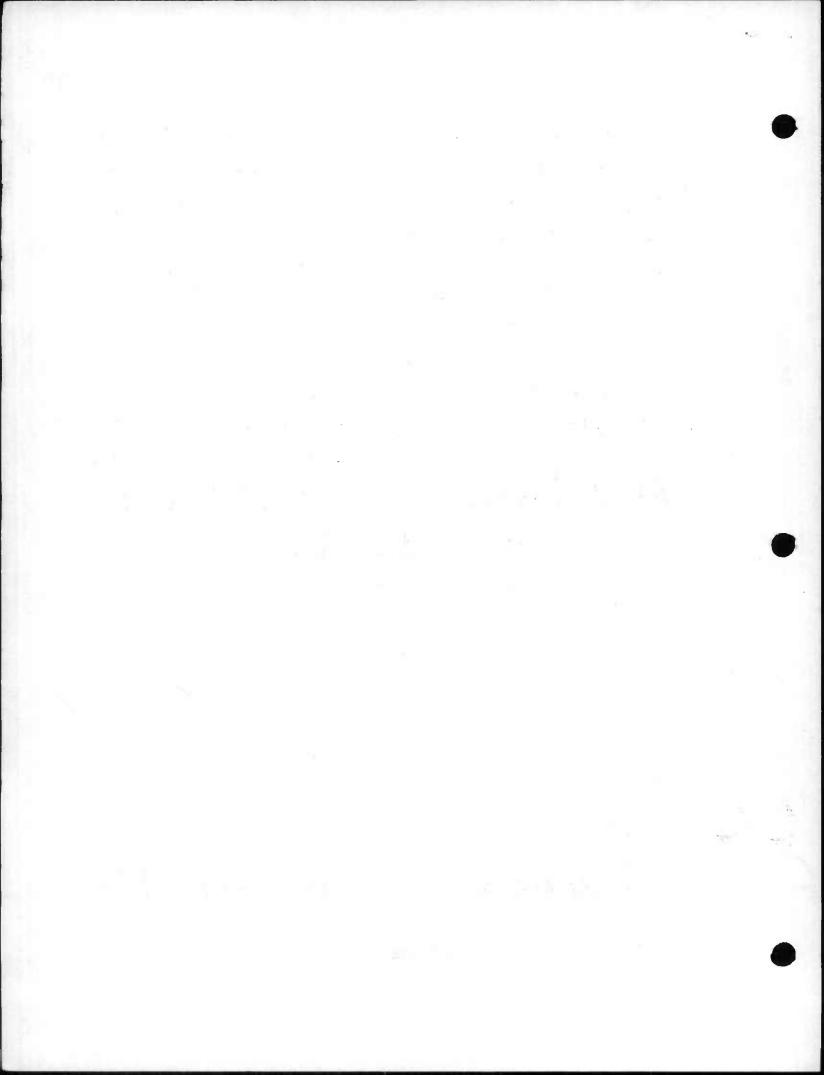
CERTIFICATE OF DEATH



93 08880

Richard Stanley Minnick Feb. 27, Nav 1993 1	TIME OF DEATH :45 P. I
RICHARD Stanley Minnick 4. SOCIAL SECURITY NUMBER 214-28-0832 1x M 2 F 72 YRS. 8. AGE (In yrs. lest birthday) YRS. 8. AGE (In yrs. lest birthday) YRS. 99. FACILITY NAME (If not institution, give etreet and number) Feb. 27, 1993 1. ADIT OF BIRTH (Month, Day, Year) YRS. 8. BIRTHPLAY MONTHS DAY'S HOURS MIN. Jan. 2, 1921 91. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH	
214-28-0832 1x M 2 F 72 YRS. MONTHS DAYS HOURS MIN. Jan. 2, 1921 M.C. 99. FACILITY NAME (If not institution, give etreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH	CE (State or Foreign
9e. FACILITY NAME (If not institution, give etreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH	
2625 Quebec School Rd. Middletown Freder	
	cick
Md. Frederick Middletown 100. COUNTY 100. CITY, TOWN OR LOCATION 100.	I. INSIDE CITY LIMITS? YES 2 X NO
10e. STREET AND NUMBER 2625 Quebec School Rd. 10f. ZIP CODE 21769 10g. CITIZEN OF WHAT U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — / Black, WP	COUNTRY?
3 □ Wildowed 4 □ Divorced	American Indien, hite, etc. Vhite
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5 +) College (1-4 or 5 +) The Decedent's USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) In FATHER'S NAME (First, Middle, Last) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) In Particular Secondary (0-12) 16. MOTHER'S NAME (First, Middle, Maiden Surneme)	
6 mechanic auto	
19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Helen E. Minnick 2625 Quebec School Rd., Middletown, Md.	21769
20s. METHOD OF DISPOSITION 1 Burlel 2 X Cremetton 3 Removel from State 4 Donetton 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory 3/2 Smithsburg, M	
21. SIGNATURE OF PUNERAL SERVICE LICENSIEE 22. NAME AND ADDRESS OF FACILITY Donald B. Thompson Funeral Home	
23. PART . Enter the diseases, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory errest,	21769
disease or condition resulting in death) a. OW NAM AR Tend Disease OF: OUE TO (OR AS A CONSEQUENCE OF): CANALA M OP ATM OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d	
a.	
PART ii. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF	RE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF GEATH (Check only one)	
EXAMINER? HOSPITAL: OTHER:	
1 YES 2 NO 1 Inpertent 2 ER/Outpatlent 3 OOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED	
2 Accident Investigation M 1 YES 2 NO	
3 Suicide 6 Could not be 4 Homicide determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route City or Yown, Stete)	Number,
29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and manner as stated.	d manner as stated.
296. SIGNATURE AND TILE OF CERTIFIED (MO	onth, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	
MAR 1 0 1993 Julie De idson Pandelle	DHIM 18 Part

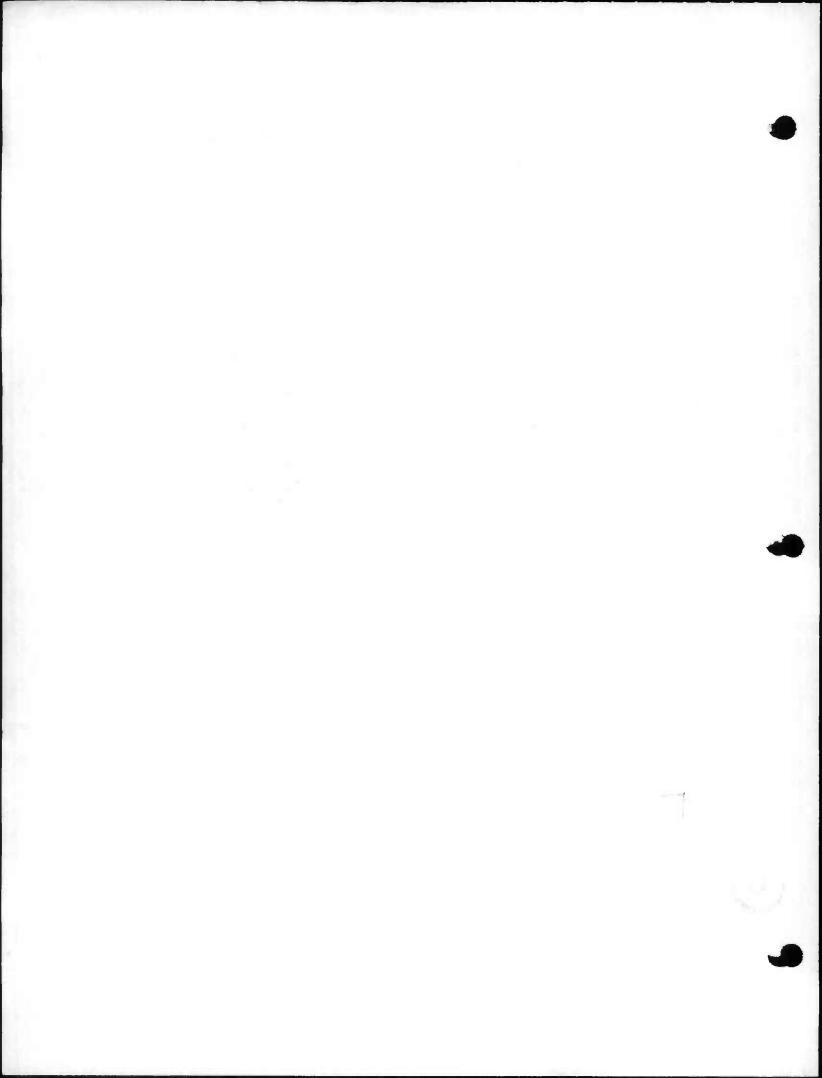
nours after death. Page 6 may be retained by the hospital or attending physician, BALTIMORE, MARYLAND 21203-3146



DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21203-3146	yours after death. Page 6 may be retained by the hospital or attending physician.	METAL DIFFCTOR: After this cardificate has been signed by the attending physician and complete, we fin by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should have after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 13146,	Purs after death. Page 6 may be retained by the hospital or attending physician.	MEMAL DIRECTOR: After this cardificate has been signed by the attending physician and completel. Led in by the funer The trans after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ME II lies 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTMENT OF I		TAL HYGIENE REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Las Margaret	Margareth	lizabeth MART		DATE OF DEATH 2/23/5	3 3. TIME OF DEATH M
	4. SOCIAL SECURITY NUMBER 577-50-75/ 9. FACILITY NAME (If not institution, give	7 1 D M 2 10 F	//n yrs. last birthday) IF UNDER 1 YEAR MONTHS DAYS		Month, Day, Year)	BIRTHPLACE (State or Foreign Country)
TOR	Sykesville RESIDENCE OF DECEDENT		are Center S	y Kesvill	e mol C	aroll
DIRECTOR		derick	Mt. Air	У		10d. INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL	14516 Shirl	ey Bohn Roa		21771	10g. CITIZE	N OF WHAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DO	U.S. ARMED 13. WAS DE	CENDENT OF HISPANIC OF Cuban, Maxican, Pur S 2 10 NO Specify:		Black, White, atc.
COMPLETED	15. DECEDENT'S EI (Specify only highest gra Etamentary/Secondary (0-12) 1.2	DUCATION ide completed) College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPAT (Give kind of work done during m hip. Do NOT use retired.) Homemaker	ON ost of working	16b. KIND OF BUSINESS/INDUS	STRY
OMI	17. FATHER'S NAME (First, Middle, Last)		Homemaner	18. MOTHER'S NAME (F	Irst, Middle, Maiden Surname)	
BE C	John Wright			Ollie	Catron	
2	19a. INFORMANT'S NAME (Typo/Print) Charlotte E.	Proviti	196. MAILING ADDRESS (Street	and Number or Rural Route	Number, City or Town, State, Zip Co	ry, Maryland
	20a. METHOD OF DISPOSITION	200	D. PLACE OF DISPOSITION (Name of co		20c. LOCATION — CII	y or Town, State
	1) Buriel 2 Cremation 3 Re 4 Donation 5 Other (Specify)		Fort Lincoln			od, Maryland
	21. SIGNATURE OF FUHERAL SERVICE	William	Olin			., Funeral H 0872-0117
	23. PART I. Enter the diseases, of ahock, or heart failur IMMEDIATE CAUSE (Final disease or condition resulting in death)	e. List only one cause on e	d the death. Do not enter the meach line.	ode of dying, such as	cardiac or reapiratory arres	
NOI	Sequentially list conditions, if any, leading to immediate	100	A CONSEQUENCE OF:	-1 0	1,18018	
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	cDUE TO (OR AS /	A CONSEQUENCE OF):			
	PART II. Other algolificant conditi	one contributing to death i	aut not reculting to the underful	a course alves in Bost	I. 24a. WAS AN AUTOPSY	24b, WERE AUTOPSY FINDINGS
MEDICAL	fremont		1 c i do- 1	ig cause given in rait	PERFORMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
N: N					1	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	OTHER:	PLACE OF DEATH (Check of	nly one)	
HYS	1 TYES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 ER/Out	25b. TIME OF 28c. IN	me 5 Realdance 6 IJURY AT 28d	Other (Specify) I. DESCRIBE HOW INJURY OCCU	RED
ВУ Р	1 Natural 6 Pending 2 Accident Investigatio	(Month, Day, Year)	INJURY W	YES 2 NO		
	3 Suicide 6 Could not I 4 Homicide detarmined	building, etc. (Spe	Y — At home, farm, street, factory, officify)	ce 261.	LOCATION (Street and Number of City or Town, State)	Rural Route Number,
COMPLETED	Control only		riedge, death occurred at the time, de on and/or investigation, in my opinion,			
DE C	29b. SIGNATURE AND TITLE OF CERTIF	Mon		29c, LICENSE NUMBER	29d. DATE:	SIGNED (Month, Day, Year)
F	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type, Print)	29c. LICENSE NUMBER	ert Rei	, toutour, Mu
*****	31. DATE FILED (Month, Day, Year) FEB 2 D	32. REGISTRAR'S SIGN				21135



HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE KINEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should list with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

OFFICIAL IN HERM 28 is marked, or Hem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAR	TMENT OF H	IEALTH AN			IE			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DA	TE OF DEATH			. TIME OF DEAT	N
	Scott	Josen	oh	Mohan		0.3		5 199	PEAR	7:00	рм
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HR		TE OF BIRTN onth, Day, Year)	BIRTHPL Country)	ACE (State or Fo.	reign	
j	218-17-1922		6 YRS.		200	Dec	2. 09 1		laryl	Land	
cc	9a. FACILITY NAME (If not institution, give s			96. CITY, TOWN (OR LOCATION O	F DEATH		9c. COUNTY	Y OF DEA	TH	
5	1614 Cedar Pa	rk Road		Annap	olis_			Ann	e A	runde]
REC	10a. STATE 10b. COUNTY	r	10c. CIT	Y, TOWN OR LOCAT	ION				10	od. INSIDE CITY	
□		1.457144-00-000							X	YES 2	NO
FUNERAL DIRECTOR		e. STREET AND NUMBER 1614 Cedar Park Road 101. ZIP CODE 2140								at country? tates	
3	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DEC			GIN? (Specify Ye				
	1XXNever Married 2 Merried	FORCES? 1 YES	2/VNO	If yes, sp	ecify Cuben, Me	xican, Puert	o Rican, atc.)	5 CI 140-	Black, V Specify:	Americen Indie Vhite, atc.	···,
B €	3 Widowed 4 Divorced				- 900				opecity.	White	2
COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade	completed)	16a. DECEDENT'S (Give kind of v	USUAL OCCUPATION CONTROL OCCUPAT	ON st of working	1	6b. KIND OF BU	SINESS/INDUS	TRY		
PE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Studen				F	ducati	aи		
MO	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S	NAME (First	t, Middle, Maiden				
BE C	James Patrick Mo	han, III					St.				
10 B	19e. INFORMANT'S NAME (Type/Print)			ADDRESS (Street e							
-	James Patrick Mo	han, III	1614	Cedar Po	vrk Roa	d An					
	20e. METHOD OF DISPOSITION 1 Buriel 2 Formation 3 Rem 4 Donation 8 Other (Specify)	oval from State	b. PLACE AND DATE Competery, cregnatory or of the LUNCOL	F DISPOSITION (Na ther place)	ma of	0/	ATE 20c. LO	CATION — CIP	y or Town	, State	
	2. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	t. Lincol	n Cremas	DADDRESS OF	3-1/-	93 Br	<u>entwoo</u>	<u>d, M</u>	aryland	1
	1 - 1 1	41/		117 D	the of	Glava	onn M.	Tayro.	r tu	neral t lis, Mi	tome
	23. PART I. Enter the diseases, pr	Sen / W	od the death. Do a								
1	shock, or neer lanure.	List only one couse on	aach line.	ot entar tha mo	ae or aying, i	uch aa ca	irdiac or reap	iratory arras	t,	Approxima	tween
	iMMEDIATE CAUSE (Final disease or condition	Gunshot	wound o	f head						Onset and	Death
	resulting in death)	DUE TO (DR AS	A CONSEQUENCE OF	7:							
Z	Sequentially list conditions,	b									
ATIC	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUENCE OF	7):							
FIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	7:						-	
CERTIFICATION	resulting in death) LAST	d.									
C	PART II. Other algnificant condition	s contributing to death	but not resulting i	n the underlying	Cauca alven	In Dart i	24a. WAS AN	ALITORAL	T ass w	THE ALITONAL CH	
		o continuing to death	but hist readiting i	ii tile ulluellylliş	cause given	in Part I.	PERFOR	RMED?	Al	ERE AUTOPSY FIR MILABLE PRIOR 1 OMPLETION OF C	то
							1.XXVES 2	NO NO	01	F DEATH?	
2 7									'	YES 2 N	10
PHYSICIAN: MEDICA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				ACE OF DEATN	(Check only	one)				
YSI	YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Out	Ipatient 3 DOA	OTHER: 4 - Nursing Hom	5 XResiden	ce 8 🗆 Ot	her (Specify)				
F	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIMI	URY WO	RK?	28d. D	ESCRIBE HOW I	NJURY OCCUP	RED		
B	2 Accident Investigation	Found 3-15-9	GI-TIT-T-C						hot		
	3 Suicide 8 Could not be determined	Found at	ectly)	ireet, tectory, other		Ci	ty or Town, Stete)	1614	Ced		r k
9 1	290. CERTIFIER 1 CERTIFYING PHYSIC			4-4-4			ad, Ann		s M	<u> </u>	
COMPLETED		CIAN: To the best of my known R: On the basis of examination							euse(e) e	nd menner as st	eted.
	200 SIGNATURE AND TITLE OF CERTIFIER		and the same of the		29c. LICENSE						
B	Mediate moi	Kall	uh			.M.E				onth, Day, Year) 5 / 1993	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	EATN (ITEM 27) (Type,	Print)	0.0	· · · · · ·			J / I	0/1993	
	MARGAMON A	· KOREU	111 Pen	n Stree	et, Ba	ltim	ore, I	Maryl	and	2120	1.
	31. DATE FILED (MORTH, Day, Year) MAR 18 199	32.4REGISTRAR'S SIGI	NATURE Sydelle						•		
	MAK 10 199	3 7									

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TO THE PASSING OF ATENDING PHYSICIAN. The two requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

The EMERIAL DIFFICURATION Amen has confident man been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

										HEG. NO	·		
	1. DECEDENT'S NAME (First,		ana Mac	0.						MONTH MONTH	DAY 1	993	3. TIME OF DEATN 8:00 P M
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. Ia	st birthdev)	IF UNDER	1 YEAR	IF UNDER	24 HBS	7. DATE OF BIRTH	1		8:00 P M
	577-10-2022	,	XX M 2 □ F	79	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	113	Counti	nr)
	9a. FACILITY NAME (If not in		/	17		9h CITY	TOWN (OR LOCATI	ON OF DE			JNTY OF D	rginia
œ			,			30. OII				ain			
8	877 Clubhou	EDENT	caye vie	<u> </u>			AVI	napo.	us_		Ann	e aru	ındel
DIRECTOR	10e. STATE	10b. COUNT	Arundel		10c. CIT	10c. CITY, TOWN OR LOCATION 10d. II							10d. INSIDE CITY LIMITS?
	MD			Ann	rapo	lis					1 YES 2 NO		
¥	10e. STREET AND NUMBER						10	. ZIP COD			10g. CIT	TIZEN OF V	WHAT COUNTRY?
FUNERAL	877 Clubho	use V	illage Vi	ew				2	1401		Un	ited	States
5	11. MARITAL STATUS	4	12. WAS DECEDEN FORCES?	T EVER IN U.S. A		13.	WAS DEC	ENDENT (OF NISPAN	IC ORIGIN? (Specify Vi	s or No-	14. RACI	E — American Indian, k, White, etc.
BY	1 Never Married 2 7	rced	IF YES, GIVE V	AR OR DATES				2/X/NO				Speci	Hy:
- 11		EDENT'S EDU	CATION	16a D	ECEDENT'S	I I I I I	CCUBATI	OM		16b. KIND OF BI	ICINECO (IN	0.10777	White
		highest grade		(0	Sive kind of Do NOT u	work done se retired.)	during mo	st of worki	ng	TOU. KIND OF BI	ISINESS/IN	DUSTRI	
4	Community (0	-12)	5		rect	24				Go	verni	mont	
COMPLETED	17. FATHER'S NAME (First, M	iddle, Lest)			recou	J. U		18. MOT	NER'S NA	ME (First, Middle, Maide		HEIL	
BE C	Clarence M	1. Mac	2.						Eliz	abeth Car	Ħ		
TO B	19a. INFORMANT'S NAME (7)	ype/Print)		19	b. MAILING	ADDRES	S (Street a	ind Numbe		loute Number, City or To		p Code)	
F	Margaret N	lace			87	7 Cli	ibho	use	Villa	rge View A	nnap	olis.	MD 21401
	20a. METHOD OF DISPOSITE		oval from State	20b. PLACE	AND DATE	OF DISPOS	SITION (N	me of		DATE 20c. L	CATION	City or To	wo State
	1 Burial 2 Cremation 4 Donation 5 Other			Ft. L	MCO	en C	rema	tory	03-	17-93 Bre	ntwo	od, 1	Maryland
	21. SIGNATURE OF FUNERAL	L SERVICE LIC	CENSEE	1		22.	NAME A	ND ADDRE	SS OF FAC	John N	. Tai	ulor	Funeral Hom
	1/2	me Y.	Din	ly_		14	17 D	uke o	of Gl	Coucester	St.	Annax	polis, MD
	23. PART i. Enter the di	seeses, or o	complications the	bused the d	eeth. Do i	not enter	tha mo	de of dy	ing, such	as cerdlec or res	iratory er	rest,	Approximate
	IMMEDIATE CAUSE (Fin		List offly offe can) se on esch lin									interval Between Onset and Desth
	disease or condition	+	/	main	-	us	no	~					
			DUE TO	(OR AS A CONSE									
8	Sequentially list conditi	ons.	b										
È I	if any, laeding to immediate. Enter UNDERLY		DOE 10	(OR AS A CONSE	OUENCE O	F):							
윤	CAUSE (Disease or Inju- that initiated events		cDUE TO	(OR AS A CONSE	OUENCE O	F):							
CERTIFICATION	resulting in death) LAS	T	4										
	DART II Out I III		THE PART OF THE PA					10.					
MEDICAL	PART ii. Other significs	nt condition	s contributing to	death but not	resulting	In the ur	nderlyin	g ceuse	given in I	Part I. 24s. WAS AI PERFO	AUTOPSY RMED?	24b.	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă		160	*							1 = YES	NO D		COMPLETION OF CAUSE OF DEATH?
										_			1 TYES 2 NO
Ä	05 440 0405 05550050 7												
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	20 500		OTHER	_	ACE OF D	EATN (Che	ck only one)			
₹	t YES 2 NO		1 Inpatient 2 28e. DATE OF		28b. TIM				sidence (8 Other (Specify)	71-0		
	1 Netural 5	Pending	(Month, D			JURY		RK?	- MO	28d. DESCRIBE HOW	INJURY OC	CURED	
à	a Contact	nvestigation	28a, PLACE O	F INJURY — At h	ome farm	street fact			NO	28f. LOCATION (Street	and Months	a Dund C	Name of the second
	_ 0 _	Could not be detarmined	building,	etc. (Specify)			,	-		City or Town, State)	or norm	louis Nombel,
9	29a. CERTIFIER , X CERT	IEVING DNVSI	CIAN: To the heat of					C. 17	0.75			2	
COMPLETED										to the cause(a) and mi) and menner as stated.
	296. SIGNATURE AND TITLE						,						
8	12	1 UPAL	lem						ENSE NUM				(Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WN	O COMPLETED CAUS	OF DEATH (ITE	M 27) /7/04	Print1			24768				15, 1993
	William A.	Dabhs	MD 4	no pida	Pari	lucia.		#100	A	apolis. N	10 01	101	
	31. DATE FILED (Month, Day,	Year)	32. REGISTRA	R'S SIGNATURE	rky f	wenu	ie '	120	Ann	upolis. N	V 214	+01	
	MAR 1 6	1993	Achia David	lson-Asna	202								
		1000		•									

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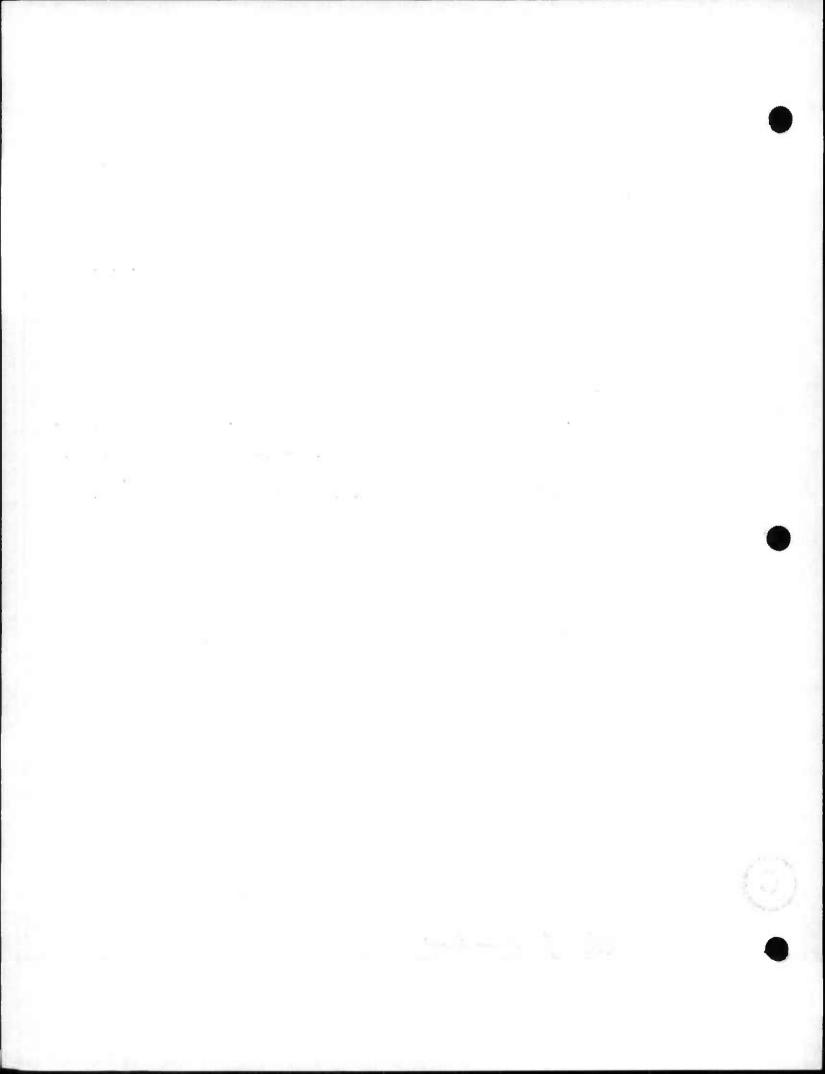
FOR STATE REGISTRAR

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	BITAL OD ATTENDING DUNCINAN. The four remainer that the death cartificate he executed within
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		JOHN 1	MORNIGST	Ar			2. DATE OF		3. TIME OF DEATH
	4.	SOCIAL SECURITY NUMBER 217-32-6763	5. SEX 6. AGE		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF I	BIRTH 19, Year) 11-37	BIRTHPLACE (State or Foreign Country)
	94	. FACILITY NAME (If not institution, give	street and number)	. \	b. CITY, TOWN	OR LOCATION OF DE	~	9c. COUNTY	
DIRECTOR	-	ESIDENCE OF DECEDENT B. STATE 10b. COUNT	suly trops	trul ASID	HAR	ar Stown	mo	WAS	Ly ton
DIRE	10		arty tow	10c. City, 1	OWN OR LOCAT	-	.		10d. INSIDE CITY LIMITS? 1 🖾 YES 2 🗌 NO
FUNERAL	10	12317 7	FORTEST A	till RT	101	D / 7			S.A.
BY FUNI	1	MARITAL STATUS Never Married 2 Married Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	If yes, sp	CENDENT OF HISPAN ecify Cuban, Mexica 2 NO Specify	n, Puerto Rice	pecify Yes or No — 14	. RACE — American Indian, Black, White, atc. Specify:
ETED		15. DECEDENT'S EDI (Specify only highest grad	te completed)	16a, DECEDENT'S US (Give kind of work life. Do NOT use n	UAL OCCUPATION done during mo	ON ost of working	16b. KIN	ID OF BUSINESS/INDUS	TRY
겁	L	Elementary/Secondary (0-12)	Coffege (1-4 or 5 +)		inest		Do	or Compa	ny
76 LUI	17.	FATHER'S NAME (First, Middle, Last) David H. Mor	ningstar					e, Meiden Surneme) Johnson	
TO BI	19 A	. INFORMANT'S NAME (Type/Print) .ntoinette I.	Morningsta	196. MAILING AD 12317	Forre	and Number or Rurel I	Rd.	City or Town, State, Zip Co Clear Sp	ring. MD.
must be	14	Burlel 2 Cremetion 3 Ref	moval from State 20b	D. PLACE AND DATE OF I	DISPOSITION /Na	ame of	DATE	20c. LOCATION — City	
examiner m	_	□ Donation 5 □ Other (Specify) SIGNATURE OF UNERAL SERVICE L		TCD 0 IIAV	T			Home, In	
medical exam	,	3. PART I. Enter the diseases, Dr	Z Daw	0	P.O.	Box 310	Clea	r Spring	, MD.21722
or ream and mental hygiene pror to burial, cremation, or shows any injury, or other traumatic event, the nameDICAL CERTIFICATION	d re	equentially list conditions, any, leading to immediate ause. Enter UNDERLYING AUSE (Disease or Injury lat Initiated eventa eauting in death) LAST	bDUE TO (OR AS A	A CONSEQUENCE OF): A CONSEQUENCE OF):		eut	Di-	eese	
	P	ART II. Other algnificent condition	ona contributing to death b	out not reaulting in t	the underlying	g ceuse given in		WAS AN AUTOPSY PERFORMED? YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
ed, or item 23 PHYSICIAN	25	. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: /	10	26. PL	ACE OF OEATH (Ch	ock anly one)		
od, or i	27.	1 N YES 2 NO	1 Inpatient 2 XER/Outp 28e. DATE OF INJURY (Month, Day, Year)		Nursing Home	URY AT		ecify) BE HOW INJURY OCCUP	RED
is mark	İ	1 Netural 5 Pending Investigation 3 Suicide 8 Could not be	28a PLACE OF IN HIDY	/ — At home, ferm, stre	M 1 🗆 '	YES 2 NO		N (Street end Number or wn, State)	Rural Route Number,
Item 28	29	Homicide determined CERTIFIER							
		(Check only	SICIAN: To the best of my know IER: On the basis of examination						
B B	29	A 5	ST Daputy u	moliel	Exa	29c. LICENSE NUN	26 C	29d. DATE 9	IGNED (Month, Day, Year)
TO	30.	NAME AND ADDRESS OF PERSON WITH HO. HO.	HO COMPLETED CAUSE OF DE	9236. L	enlo	N UIA	16 1	throis	town mi
	31.	DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE					

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 3 CERTIFICATE OF DEATH REG. NO.

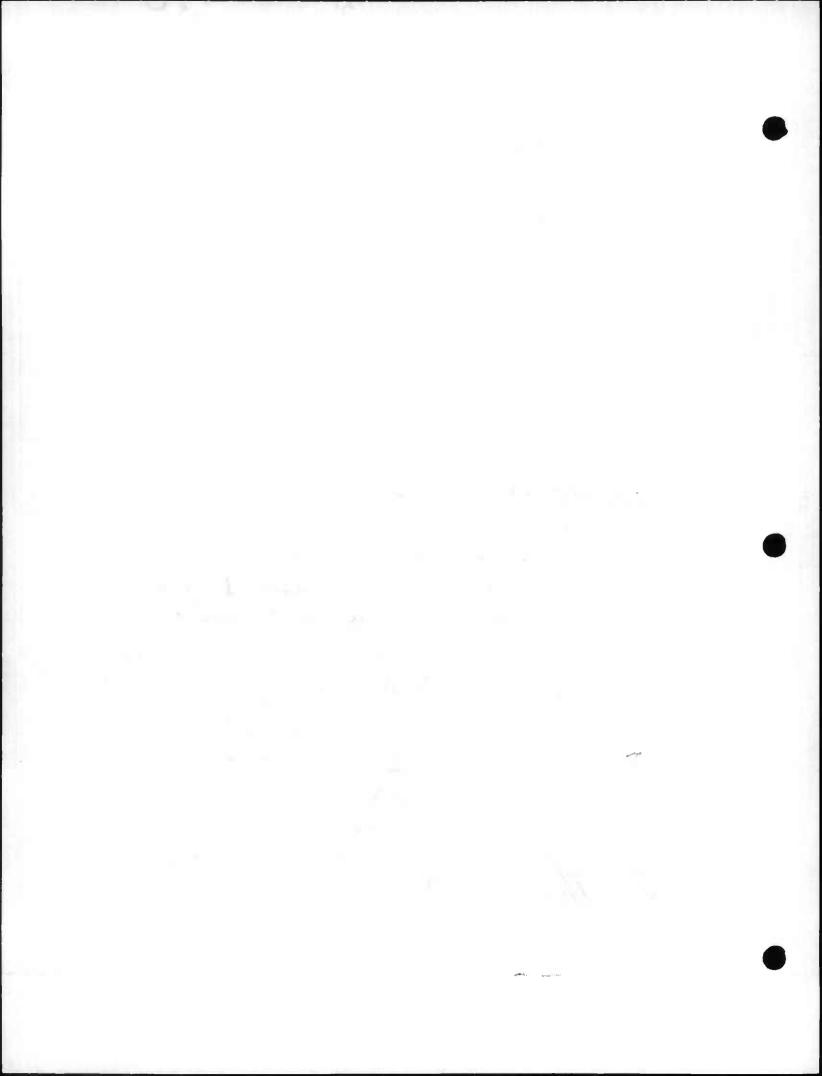
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

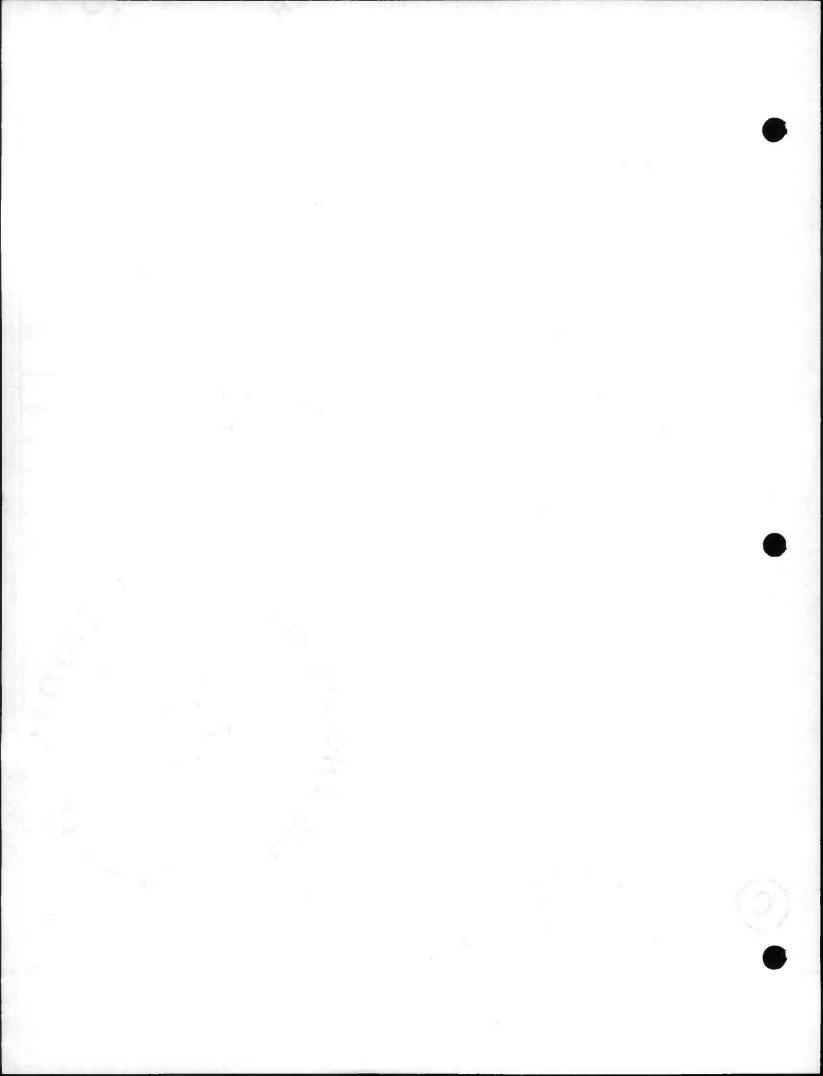
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	i i	1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE OF D	EATH			3. TIME OF DEATH
	•	Helen Lo	nice M	FRT7							March	11	199	YEAR	6:20 A.M. M
	-1	4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In yrs. la	st hirthday)	IF LINDS	ER 1 YEAR	IE IMOE	R 24 HRS.	7. DATE OF BI		193		HPLACE (State or Foreign
	4	170 10 00//		1 M 2 V F		YRS.	MONTHS	-	HOURS	MIN.	(Month, Day,	Year)	1006	Count	ry)
- 1	į	179-18-9244 se. FACILITY NAME (If not in		1	86	1110.						12			nsylvania
						9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF									
3	2	Washingt		Ha	gerst	cown				Was	shing	gton			
905		10a. STATE		10c. CITY, TOWN OR LOCATION									10d, INSIDE CITY		
2		Maryland	Was	hington			На	gersi	Own						L/MITS?
		10e. STREET AND NUMBER		8		Hagerstown							100 CIT	17EN OF 1	1 YES 2 NO
FLINEDAL		1749 Edgew	ood Hi	11 Circl	a Ant	104		1 10		1740				5.A.	WHAT COUNTRY
1 2		11. MARITAL STATUS	004 111		T EVER IN U.S. A		40	WE O DEC			HC ORIGIN? (Spe				
	- 11	1 Never Married 2	Merried	FORCES?	YES 2 X		13	If yes, sp	ecify Cub	an, Mexica	n, Puerto Ricen,		1 OF 140—	14. HAC	E — American Indian, k, White, atc.
2		3 Widowed 4 Divo	rced	IF YES, GIVE Y	MAR OR DATES			1 U YES	2 (£) NO	Specify	y:			Spec	"White
TED	1		EDENT'S EDU			ECEDENT'S					18b. KIND	OF BU	SINESS/IN	DUSTRY	
l L		Elementary/Secondary (0	highest grade -12)	College (1-4 or 5	- 46	Sive kind of a Do NOT u	work done se retired.	e during ma .)	st of work	ing					
وَ ار		10				Hou	ısew	ife							
once.		17. FATHER'S NAME (First, M.	iddle, Lest)						16. MOT	HER'S NA	ME (First, Middle,	Meiden	Sumame)		
= u	. 1	Joseph Rod	gers						Ama	anda	Hill R	odge	ers		
TO B		19a. INFORMANT'S NAME (7)	/pe/Print)		15	b. MAILING	ADDRES	SS (Street o			Route Number, Cli			p Code)	
2 F		Dorothea S	chaffe	r		23 E	Bitt	erswe	eet 1	Drive	Hage	rst	own,	Md.	21740
١		20a. METHOD OF DISPOSITI		mel from State	20b. PLACE	ANDDATE	OF DISPO	SITION /Na	me of		DATE		CATION —		
Ē		4 Donation 5 D Other		Over Holl State	cemetery, cr Hage	rstow	m C	remat	ory	3-11	-93	Hage	ersto	wn,	Maryland
e l	(21. SIGNATURE OF FUNERA			45	4	22	. NAME A			CHLITY				Home
examiner must be notified at once.		> 3C	set,	mi	rmen	ed		415 F	. W-	11sor	Blvd.				, Md. 21740
E 9		23. PART i. Enter the di	seases. Dr d	omplications the	t coused the d	eeth Do							_		Approximate
DeE	4	ahock, Dr he	eart feilure.	List only one car	use on each line	е.	iot dine		aa or ay	mg, sec	ii as cardiac c	и тевр	retory at	reat,	interval Between
- F		iMMEDIATE CAUSE (Fin disease or condition		Carol						L					Onset and Death
H,	ŀ	resulting in death)		Cardi	OF AS A CONSE	QUENCE O	E)	all	62			_			
or other traumatic event, the medical	.			Diff. o	OF AS A CONSE OF AS A CONSE	cati	~ ·	000	Die	2000	cular		Dire		
y, or other traumatic		Sequentially list conditi		DUE TO	(OR AS A CONSE	OUENCE O	F):	car	CIL	1043	Cular		156	45	
TAT		cause. Enter UNDERLYI	NG	wite	Cor	nape	fin		hea	rt	fail	USE	0		1
ther IF		CAUSE (Diseese or inju that initiated events	D.	DUE TO	(OR AS A CONSE	OVENCE O	F):		, ,	1	(-(()				
0 0		resulting in death) LAS	T	d											
	- 11	PART II. Other significa	nt condition	n emetalbustan sa	death has an										
ows any Injury,											Part i. 24a.	WAS AN PERFOR	AUTOPSY MED?	245	MAILABLE PRIOR TO
E 1		Tracke 1	1402	ardial	1010	RICT	lon	?	119:	3	1 🗆	YES 2	NO		OF DEATH?
-											_				1 - YES 2 - NO
2 Z															
r Item		25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:			OTHE		ACE OF I	DEATH (Ch	eck only one)				
		1 YES 2 NO		1 Inpatient 2		1	4 🗆 Nu	ursing Hom		esidence	6 Other (Spe	c#y)			
PHY		27. MANNER OF DEATH 1. Natural 5	Pending	28s. DATE Of (Month, L		28b. TIM	IE OF JURY		RK?		28d. DEŞCRIBI	E HOW I	NJURY OC	CURED	
marked,			nvestigation		- salitation		М		/ES 2 [] NO					
28 is			Could not be	building,	OF INJURY — At he etc. (Specify)	ome, farm,	street, fa	ctory, offic	•		261. LOCATION City or Tow		end Numbe	r or Rural i	Route Number,
ETE															
ANT: If Ite				CIAN: To the best of											
E S		MEDI	CAL EXAMINE	R: On the basis of s	examination end/or	investigation	on, in my	opinion, d	eath occu	red at the	time, date and p	elece, an	d due lo ti	he cause(e) and manner ee stated.
토		296. BIOMAZIME AND TITLE	OF GENTAUE		- ~				29c. LIC	ENSE NUA	ABER .		29d. DAT	E SIGNED	(Month, Day, Year)
≥ O	- 11	/ Korge	The	mar	_II ph	1.1.	4.1).	1)	17	591		1 3	3/111	93
= 2		30 MANU AND ADDRESS OF	PERSON WH	O COMPLETED CAU	SE OF DEATH (ITE	М 27) (Туре	, Print)							111	
		ľ	102												
		31. DATE FILED (Month, Day. MAR 1	1993	32. REGISTRA	AR'S SIGNATURE	. 4.4.6									



DIVISION OF VITAL RECORDS, P.O. BOX 68760	-
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	EX	irst, Middle, Last	m		m-	· L	12.			2. DATE OF DEAT MONTH arch 8,	7993	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NU	he/	5. SEX	6. AGE (II	n yrs. lest birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS	7 DATE OF BIRT	4	a. BIRTHE	PLACE (State or Forei
	219-36-49	93	1 🗆 M 2 💢 F	9.	6 YRS.	MONTHS	DAYS	HOURS	MIN.	July 22	1896	Gountry Marti	yland
BO	90. FACILITY NAME (# 100 Washingto		,	al		эь. сту, Наде			ON OF DEA	тн		nty of DE hingt	
DIRECTOR	RESIDENCE OF D	ECEDENT 10b, COUN	ITY		too Cr	ry, town o	O LOCAT	TION					10d. INSIDE CITY
DIR	Maryland	Fred	erick			ersu.							LIMITS?
ERAL	13347 Spr		n Road				101	1. ZIP COD	773				HAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 D		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 NO	1 1	yes, sp	CENDENT Concept Cube	n, Mexican,	ORIGIN? (Specif Puerto Rican, etc	y Yes or No	14. RACE Black, Specify	- American Indian, White, atc.
PLETED		ECEDENT'S ED only highest grad y (0-12)		+)	16a. DECEDENTS (Give kind of life. Do NOT of Teacher	work done one retired.)	CUPATIO	ON ost of workli	ng		BUSINESS/INI		
BE COMPL	17. FATHER'S NAME (First, William F	. Lewi	S					M	ary S	E (First, Middle, M.	rrest		
70	W. Melvin				19b. MAILIN	Ple	(Street a	nd Number V	or Aural Ao Lley	Rd., Sn	r Kown, State, Zij Lithsbu	rg, N	ND 21783
	20s. METHOD OF DISPOS 1 M Buriel 2 Crema 4 Donation 5 Oth	ition 3 🗆 Rei	moval from State	20b.	PLACE AND DATE etery, crematory or UE KLUG	of DISPOS	TION (Na	ame of	3/	DATE 20	LOCATION —		
	21. SIGNATURE OF SUME		LICENSEE		ue krug		_		SS OF FACI				
	1	14.	Delis	7. 1		D:	abat	++, T		0 11			Street
	IMMEDIATE CAUSE (' neart tallure Finei	c. List only one cet	use on ea	ich line.	not enter	the mo	ode of dy	ing, such		_		Approximat
ERTIFICATION	snock, pr	ditiona, nediate LYING njury	a. ASP DOE TO DUE TO C.	OF AS A	ich line.	PN (the mo	ode of dy	ing, such	as cardiec or i	_		Approximat Interval Bet
CAL CERTIFICATION	IMMEDIATE CAUSE (il disease or condition resulting in death) Sequentially list conditions, leading to immicause. Enter UNDERI CAUSE (Disease or in that initiated events	ditiona, nediate LYING njury	a. ASP DOE TO b. ALZ DUE TO c. DUE TO	OF AS A	CONSEQUENCE CONSEQ	PN (the mo	nde at dy	ing, such	as cardiec or r	_	24b.	Approximat interval Bet Onset and On
CAL	IMMEDIATE CAUSE (il disease or condition resulting in death) Sequentially list conditions are in any, leading to immicause. Enter UNDERI CAUSE (Disease or in that initiated events resulting in death) Li	ditiona, nediate LYING njury	a. ASP DOE TO b. ALZ DUE TO c. DUE TO	OF AS A	CONSEQUENCE CONSEQ	PN (the mo	nde at dy	ing, such	as cardiec or r	espiratory ar	24b.	Approximat Interval Bet Onset and Interval Be
: MEDICAL	SHOCK, OF IMMEDIATE CAUSE (I disease or condition resulting in death) Sequentially list concil fam, leading to immicause. Enter UNDERI CAUSE (Disease or in that initiated events resulting in death) L./	ditiona, nediate LYING night of the conditional condit	a. ASP DOE TO b. ALZ DUE TO c. DUE TO	OF AS A	CONSEQUENCE CONSEQ	PN (the mo	nde at dy	ing, such	as cardiec or r	S AN AUTOPSY RECORMED?	24b.	Approximatinterval Bet Onset and I
: MEDICAL	IMMEDIATE CAUSE (I disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter UNDER! CAUSE (Disease or in that initiated events resulting in death) L/ PART II. Other significations are successful to the significant in the significa	ditiona, nediate LYING night of the conditional condit	a. ASP DOE TO DUE TO C. DUE TO d. HOSPITAL:	O (OR AS A O (OR AS A O OR AS A	CONSEQUENCE CONSEQ	POTHER	the mo	Dide of dy	ing, such	art I. 24a. We PE 1 YI	S AN AUTOPSY PRORMED?	24b.	Approximat Interval Bet Onset and Interval Be
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PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (II diseese or condition resulting in death) Sequentially list come if any, leading to immediate. Enter UNDER! CAUSE (Disease or in that initiated events resulting in death) L. PART II. Other significations are considered in the signification of the significant of the signi	ditiona, nediate LYING night of the conditional condit	a. ASP DOBE TO DOBE TO DUE TO C. DUE TO d. DUE TO D	O (OR AS A O (OR AS A	CONSEQUENCE CONSEQ	OTHER JURY	26. PLI: ing Hom	g ceuse	given in P	art I. 24a. Wa PE 1 YI	S AN AUTOPSY RECORMED?	24b.	Approximatinterval Bei Onset and
ED BY PHYSICIAN: MEDICAL	Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting to immoderate conditions are sequentially listed events resulting in death) L. PART II. Other significations are sequentially listed events resulting in death) L. PART II. Other significations are sequentially listed events resulting in death) L. 25. WAS CASE REFERRED EXAMINER? 1	ditiona, nediate LYING njury AST	B. LIST DNIY ONE CET B. DUE TO C. DUE TO C. DUE TO d	O (OR AS A O (OR AS A	CONSEQUENCE CONSEQ	OTHER JURY	26. PLI: ing Hom	g ceuse	given in P	art I. 24a. Wa PE 1 YI	S AN AUTOPSY PRORMED? ES 2 NO OW INJURY OC	24b.	Approximat Interval Bet Onset and Interval Bet Onset and Interval Bet Interval Bet Interval Bet Interval Bet Interval Bet Interval Bet Interval Bet Interval Bet Interval Bet Interval Bet Interval Bet Interval Bet Interval
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ED BY PHYSICIAN: MEDICAL	Sequentially list concidences or condition resulting in death) Sequentially list concidences or including to imministration of imministra	ditiona, nediate LYING njury AST Could not be determined ERTIFYING PHYSECOCAL EXAMIN	a. ASP DOE TO DOE TO DU	O (OR AS A O (OR AS A	CONSEQUENCE CONSEQ	OTHER 4 Num AE OF JURY M atreet, factored at the ti	26. PLL 26. PLL 27. PLL 28. INJ 1 NO	g ceuse g LACE OF D META BURY AT PRES Bury AT Bury	given in P	art I. 24a. When PE I I I YI I I I I I I I I I I I I I I I	S AN AUTOPSY REORMED? ES 2 NO OW INJURY OC Intest and Number State) If manner as ata	24b. 24b. CCURED or or Rural Ro	Approximatinterval Bet Onset and I Onset a
E COMPLETED BY PHYSICIAN: MEDICAL	SHART II. Other signification of the significant of the significa	ditions, nediate LYING njury AST Cent condition investigation Could not be determined RTIFYING PHYSEDICAL EXAMINATION OF THE P	B. Liet only one cet a. ASP Del TO DUE TO C. DUE TO d. DUE TO d. DOES CONTributing to PHOSPITAL: 1 Del TO 2 Del TO 3 Del TO 4 Del TO 4 Del TO 4 Del TO 4 Del To 4 Del To 5 Del TO 4 Del To 5 Del TO 6 Del To 6 Del To 6 Del To 6 Del To 6 Del To 6 Del To 6 Del To 6 Del To 7 Del To 6 Del To 6 Del To 7 Del To 6 Del To 6 Del To 7 Del To 7 Del To 8 Del To 9	D (OR AS A D) (OR	CONSEQUENCE CONSEQ	OTHER JURY M atreet, factor at the ti-	26. PL 26. PL 26. PL 27. The second of th	g ceuse g LACE OF D META BURY AT PRES Bury AT Bury	given in P	art I. 24a. When PE I I I YI I I I I I I I I I I I I I I I	S AN AUTOPSY RFORMED? S 2 NO OW INJURY OC treet and Number State) If manner as state, and due to till 29d. DAT	24b. 24b. CCURED or or Rural Ro	Approxima Interval Be Onset and Onse

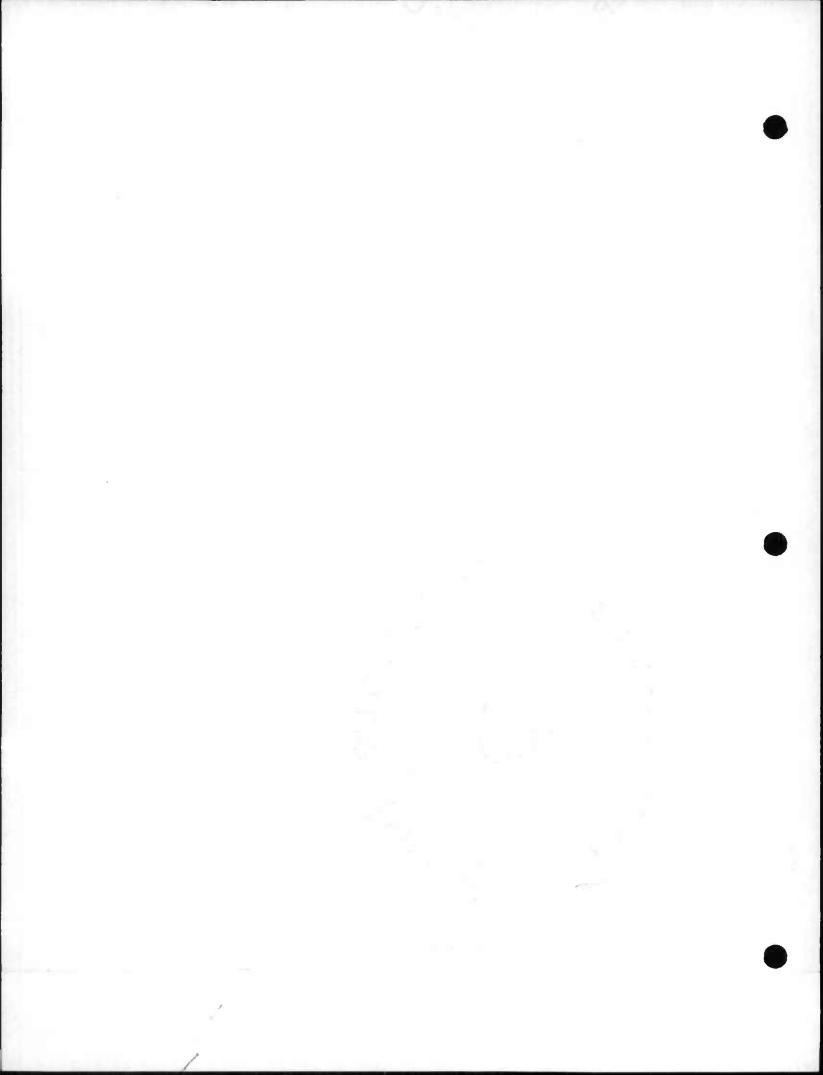


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TO THE MISSING WITHOUT A TTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be	TO THE TURES. CHRESTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page	IMPORTANT If them 28 is marked, or item 23 shows any injury, or other traumatte event, the medical examiner must be
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31. DATE FILED (Month, Day, War)
WAR 15 1993

32. REGISTRAR'S SIGNATURE

	- OTHE		MENT OF HEALTH AND		E	8887
	1. DECEDENT'S NAME (First, Middle, Last) Madelin	ne Marie Monn	CATE OF DEATH inger		AY YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 218-30-7685 1 □ M 2 ☒ F	8. AGE (In yrs. last birthday)	F UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF D	July 20,	1933 Ma	
TOR	Washington County Hospi	al	Hagerstown		Washi	ngton
DIRECTOR	Maryland Washingt		Hagerstown			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	Route 9, Box 155		10f. ZIP CODE 21740		10g. CITIZEN OF	WHAT COUNTRY?
BY FUN	1 Never Married 2 X Married FORCES?	NT EVER IN U.S. ARMED 1 ☐ YES 2 1 NO WAR OR DATES	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic 1 YES 2 NO Speci	nn, Puerto Rican, etc.)	s or No — 14. RAC Blo	CE — American Indian, ck, Whita, atc.
8	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S L	ISUAL OCCUPATION ork done during most of working	16b. KIND OF BU	SINESS/INDUSTRY	
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5 0-10	Min Do MOT une	retired.)	organ	mfg.	
CON	17. FATHER'S NAME (First, Middle, Lest) Luther Petr	re	18. MOTHER'S N.	ME (First, Middle, Meiden Beulah	Surname) P. Wolfo	rd
BE	19a. INFORMANT'S NAME (Type/Print)		ADDRESS (Street and Number or Rural			T d
2	Mr. Leroy E. Monninger		e 9, Box 155, H			d 21740
	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	F DISPOSITION (Name of per place)	DATE 20c. LO	CATION — City or 1	fown, State	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF F		nnich Fu	neral Home
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a						Approximate Interval Between Onset and Beath Well Co.
	cause. Enter UNDERLYING CAUSE (Disease or Injury	O (OR AS A CONSEQUENCE OF)	:	1 Chian	ra	415.
: MEDICAL	PART II Other algorificant conditions contributing to	deeth but not resulting in	the underlying couse given in	Part I. 24a. WAS AN PERFOR	MEDI	b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEATH (C	neck only one)		
5 ≥		☐ ER/Outpetlent 3 ☐ DOA	4 Nursing Home 5 Residence			
ВУ РН		Day, Year) 286. 11ME INJU		28d. DEŞCRIBE HOW I	NJURY OCCURED	
9	3 Suicide 6 Could not be 4 Homicide detarmined	OF INJURY — At home, farm, st , atc. (Specify)	reet, factory, office	261. LOCATION (Street City or Town, State)		Route Number,
COMPLE	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of cone) 2 MEDICAL EXAMINER: On the basis of cone					(s) and manner as stated.
O BE COM	296. SIGNATURE AND TITLE OF CERTIFIERS	any m	O Sec LICENSE MU	398	29d. DATE SIGNS	12/93
	30. HAME AND ADDRESS OF PERSON WHO COMPLETED CALL	SE OF DEATH (ITEM 27) (Typo, 1	635. Clevel	and Dur	e. Ha	g. nd



REG. NO

2. DATE OF DEATH

BALTIMORE, MARYLAND 21215-0020

FOR

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STATE REGISTRAR

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DIVISION OF VITAL RECORDS, P.O.	The second second second second
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31. DATE FILED (Month, Day, Year MAR 18 93

DECEDENT'S NAME (First, Middle, Lest) Lemyel 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 212-03-4443 1300M 2 - F 6/11/17 permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN DR LOCATION OF DEATH DIRECTOR Harford Memorial Hospital Havre de Grace 10b. COUNTY 10¢ CITY, TOWN OR LOCATION Maryland Harford Aberdeen FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE use as the burial-transit 127 Baltimore Street 21001 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TYES 2 X NO BY Specify 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ò College (1-4 or 5+) detached 10 0 Clerk once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) funeral director, page 5 should be notified at John L. McFadden, Sr. Laura V. Neidlein 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Floute Number, City or Town, State, Zio Code) 2 Mrs. Evelyn M. McFadden 127 Baltimore St 99 20e. METHOD OF DISPOSITION
1

Burlel 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 1 Buriel 2 Cremation 3 L 4 Donation 8 Other (Specify) Spesutia Cemetery 3/19 exeminer 21. SIGNATURE OF FUNERAL BERVICE LICEN 22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 attending physician and completely filled in by the mal Hyglene prior to burial, cremation, or removal. the medical 23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition executed within event. resulting in death) DUE TO (OR AS A CON traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other Mental Hyglene that initiated events resulting in death) LAST 6 of Health and Mer PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. WAS AN AUTOPSY MEDICAL PERFORMED? eny I VES 2 - NO Shows this certificate has been with the State Dept. of PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) atient 2 - ER/Outpatient 3 - DOA 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED merked. 1 National 1 YES 2 ND BY After death 2 Accident OR ATTENDING 28s. PLACE OF INJURY — At I building, etc. (Specify) 28 ls DIRECTOR: / BE COMPLETED 4 Homicide Hem 29a. CERTIFIER

(Chack only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type,

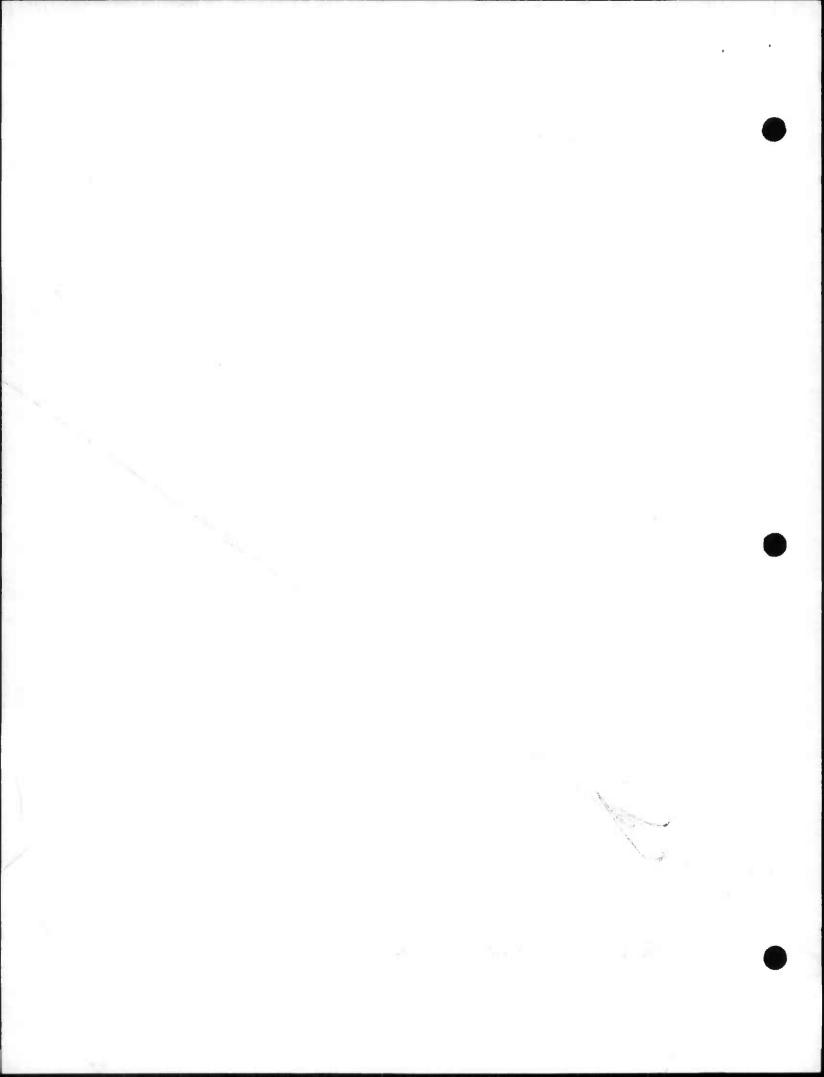
32 REGISTRAR'S SIGNATURE Aulia Davidson Pandette

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

3. TIME OF DEATH 8. BIRTHPLACE (State or Foreign Maryland 9c. COUNTY OF DEATH Harford 10d. INSIDE CITY 1X YES 2 ND 10g, CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, etc. White Beverage Distributor Aberdeen, Maryland 21001 20c. LOCATION - City or Town, State Perryman, Maryland Approximate Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AMAJLABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO 261. LOCATION (Street and Number or Rural Route Number, City or Tayn, State) 29d. DATE SIGNED (Month, Day, Year) 3 93

DHMH-18 Rev 1/89



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

- 0	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH		3. TIME OF DEATH
- 8	CLARA	4	MONZ	EGL	10		MONTH D	1 100	YEAR 1850 M
		5. SEX 6. A	GE (In yrs. last birthday,			R 24 HRS.	7. DATE OF BIRTH	7 190	8. BIRTHPLACE (State or Foreign
8	261-41-8853	1 🗆 M 2 🕞 🗜	86 YRS.	MONTHS	DAYS HOURS	MIN.	Aug 13	1906	Country Ta L
E	96. FACILITY NAME (If not institution, give stre PENINSULA REGIONA.		CENTER		OWN OR LOCAT		ATH /		TY OF DEATH COMICO
RECTOR	RESIDENCE OF DECEDENT								
Ä	10e. STATE 10b. COUNTY		10c. CI	TY, TOWN OR	_				10d. INSIDE CITY LIMITS?
□	100. STREET AND NUMBER	nerseT		We	stove		······		1 TYES 2 NO
FUNERAL	25724 Dru	n PoinT	Rd.		101. ZIP COO	18	7/	10g. CITI	ZEN OF WHAT COUNTRY?
5	11. MARITAL STATUS	12. WAS DECEDENT EVI		13. W	S DECENDENT	OF HISPAN	IC ORIGIN? (Specify Yes	or No-	14. RACE — American Indian,
B	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR O			YES 2 July		, Puerto Rican, etc.)		Specify: White, etc.
8	15. DECEDENT'S EDUCA (Specify only highest grade co		16a. DECEDENT		UPATION ring most of work	ina	16b. KIND OF BUS	SINESS/IND	USTRY
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT	use retired.)					
O	17. FATHER'S NAME (First, Middle, Last)				18. MOT	NER'S NAI	NE (First, Middle, Maiden	Sumame)	
BE	Screno Mon	Zeglio			CA	Len	cnTing	17	onzesto
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS (Street and Number		oute Number, City or Town		Coole)
임	Lewis Monz	egLID	257	240	rum F	oint	Ad West	DYET	Md 21871
	20a. METNOD OF DISPOSITION 1 Burial 2 Cremation 3 Remov	el from State	20b. PLACE AND DATE		ON (Name of		DATE 20c. LO	CATION —	City or Town, Stats
	4 Donation 5 Other (Specify)			ury (cen	tory	115 50	Lisby	my Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE			ME AND ADDRE		omerse	7	Ave
	James J	Honnie	7		Drine		Anna	N	21853
	23. PART I. Enter the diseeses, or co	mplications that cau	sed the death. Do	not enter th	ne mode of dy	ing, such	as cardiac or respi	ratory arm	est, Approximate
	shock, or heart failure. Li IMMEDIATE CAUSE (Final	st only one cause o	n each line.						Interval Between Onset and Death
	diseese or condition resulting in death)	Aci	La Myc	0000	1,0	7	los et	-	
	iteating in death,					and a	7.400		
Z	Sequentially list conditions,	Cor	S A CONSEQUENCE	AR	TERY	D	IS EAST		
CERTIFICATION	if any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE	OF):					
할	CAUSE (Disease or injury	DUE TO (OR	S A CONSEQUENCE	NE.					
Ē	that initiated events resulting in death) LAST	DOE TO (OH)	S A CONSEQUENCE	<i>JF</i>]:					7 1
ë	d.								
	PART II. Other aignificent conditions	contributing to deal	h but not resulting	in the und	erlying cause	given in l	Part I. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS
EDICAL	HYDERT	EN SIOW					1 YES 2	- 1	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
S 1	DIMBETE	5 MG	LITUS						1 TYES 2 NO
ž									
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF I	DEATN (Che	ck only one)		
SIC	1 TES NO	HOSPITAL:	Outpatient 3 DOA	OTHER:	g Home 5 🗆 R	ssidence	B Other (Specify)		
Ě	27. MANNER OF DEATN	26s. DATE OF INJU (Month, Day, Ye.		ME OF 2	Bc. INJURY AT WORK?		28d. DESCRIBE NOW II	NJURY OCC	CURED
ВУ	1 Natural 5 Pending 2 Accident Investigation	(Martin, Bey, 10	"	M	1 YES 2	□ NO			
0	3 Suicide 6 Could not be	26e. PLACE OF INJ building, atc. (JRY — At home, ferm, Specify)	street, factor	y, office		26f. LOCATION (Street a City or Town, State)	and Number	or Rural Route Number,
ш			,,				Ony or lown, clare,		75
	4 Nomicide determined				-	_			
PLET		AN: To the best of my k	nowledge, death occur	red at the tim	e, date and place	, and due	to the cause(s) and man	mer as state	ed.
OMPLET	29e. CERTIFIER 1 CERTIFYING PHYSICI.								ed. e cause(s) and menner as stated.
COMPLETE	29e. CERTIFIER 1 CERTIFYING PHYSICI.				nion, death occu		lime, date and place, an	d dus to the	e cause(s) and menner as stated.
BE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	On the basis of examin	ation and/or investigat	lon, in my opi	nion, death occu	end at the	lime, date and place, an	d dus to the	e cause(s) and menner as stated. E SIGNED (Month, Day, Year)
	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	On the basis of examin	ation and/or investigat	lon, in my opi	nion, death occu	end at the	lime, date and place, an	d dus to the	e cause(s) and menner as stated. E SIGNED (Month, Day, Year)
BE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	On the basis of examin	ation and/or investigat	lon, in my opi	nion, death occu	end at the	lime, date and place, an	d dus to the	e cause(s) and menner as stated.



1. DECEDENT'S NAME (First, M Katie 4. SOCIAL SECURITY NUMBER	liddle, Last)	OLITTI			100	DEC A	10		
			ICATE O	DEAL	T .	REG. N 2. DATE OF DEATH MONTH		YEAR 3	TIME OF DEATH
4. SOCIAL SECURITY NUMBER	S. Morga	ın.							6:30 P
		6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	-		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPL Country)	ACE (State or Foreign
212-16-12	63 1 M 2 T F	94 YRS.	WONTHS DAYS	HOURS	MIN.	Aug. 18,			yland
9a. FACILITY NAME (If not instit	tution, give street end number)		9b. CITY, TOWN	OR LOCATIO	ON OF DEA	тн	9c. COU	NTY OF DEA	TH
Alica Byr RESIDENCE OF DECE 100. STATE 1	d Tawes Nur	sing Home	Cri	sfield	d, MD)		Somer	set
1 10e. STATE	0b. COUNTY	10c. CIT	Y, TOWN OR LOC					1	Dd. INSIDE CITY
	Somerset		Cris	field				1	YES 2 NO
10e. STREET AND NUMBER				10f. ZIP CODE			10g. CITI	ZEN OF WH	AT COUNTRY?
2577 Lloyd V	Webb Rd.			2	1817			U.S.	Α.
10e. STREET AND NUMBER 2577 Lloyd V 11. MARITAL STATUS 1 Never Married 2 Me 3 X Widowed 4 Divorce	FORCES?	NT EVER IN U.S. ARMED I YES 2 NO WAR OR DATES	If yea,	ECENDENT Of specify Cuber ES 2 10 NO	n, Mexican,	ORIGIN? (Specify Puerto Rican, etc.)	Yee or No	14. RACE - Black, 1 Specify:	American Indien, White, etc.
15. DECED	ENT'S EDUCATION ighest grade completed)	16a. DECEDENT'S	USUAL OCCUPA	TION		16b. KIND OF	BUSINESS/IND	USTRY	
Elementary/Secondary (0-12		Ma Do MOT u	work done during a se retired.)	most of working	9				
Grade 4		Process	sor			Seaf	ood		
15. DECED (Specify only h Elementary/Secondary (0-12 Grade 4 17. FATHER'S NAME (First, Middle)	le, Last)			18. MOTH	ER'S NAM	E (First, Middle, Meio			
	erling					an J. Ty			
100 INFORMANTIO MARKE (To-		196, MAILING	AODRESS (Stree			ute Number, City or 1		Codel	
Dollie Widdo	owson (Daughte		as 10 a				orri, orana, Lap	3330)	
20e. METHOD OF DISPOSITION 1 Buriel 2 Cremation 4 Donation 5 Other (S)	3 Removal from State	20b. PLACE AND DATE cemetery, crematory or canal control of the co	other plecel		3/12/	1	Crisfi		
21. SIGNATURE OF PUNERAL S	SERVICE LICENSEE	TABOUTY CC		AND ADDRES			CLISLI	leiu,	ייי
	Bradshay		306	W. Ma	in St	ns Funera t Cris	sfield	, MD	21817
IMMEDIATE CAUSE (Final disease or condition resulting in death)	ases, or complications the rt fellura. List only one certain a.	at caused the death. Do use on each line.	not enter the n		ng, auch	7	spiratory arr	eat,	Approximata Interval Batwe Onset and Da
Sequentially list condition		(OR AS A CONSEQUENCE O	n.						Jeans
If any, leading to immedia cause. Enter UNDERLYING	ita 💮	(OII AS A CONSCORDE O	· ,.						1
CAUSE (Disease or injury that initiated events	C	(OR AS A CONSEQUENCE O	F):						
resulting in death) LAST	d								
PART II. Other significant	conditiona contributing to	death but not resulting	In the underly	ng cause g	iven in P	PERF	AN AUTOPSY ORMED?	A)	ERE AUTOPSY FINDIN MILABLE PRIOR TO OMPLETION OF CAUSI F DEATH?
						-		1	YES 2 NO
25. WAS CASE REFERRED TO M	MEDICAL		26.	PLACE DF DE	ATH (Chec	k only one)			
EXAMINER?	HOSPITAL:	- FD10-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	OTHER:						
25. WAS CASE REFERRED TO BEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	28e. DATE OF	ER/Outpetlent 3 DOA INJURY 28b. TIM		NJURY AT		Other (Specify)	N IN IN ITEMS OF THE	NIDEO.	
III 1 AMPRITURE 5 Per	(Month, E		JURY V	VORK?		18d. DESCRIBE HOY	W INJUSTY OCC	URED	
2 Accident Inv	estigation 28e. PLACE C	OF INJURY — At home, farm, etc. (Specify)		YES 2		281. LOCATION (Stree City or Town, Sta		or Rural Rou	te Number,
	/ING PHYSICIAN: To the best of								
	L EXAMINER: On the beele of e								

W. Main St.

- Crisfield, MD

21817

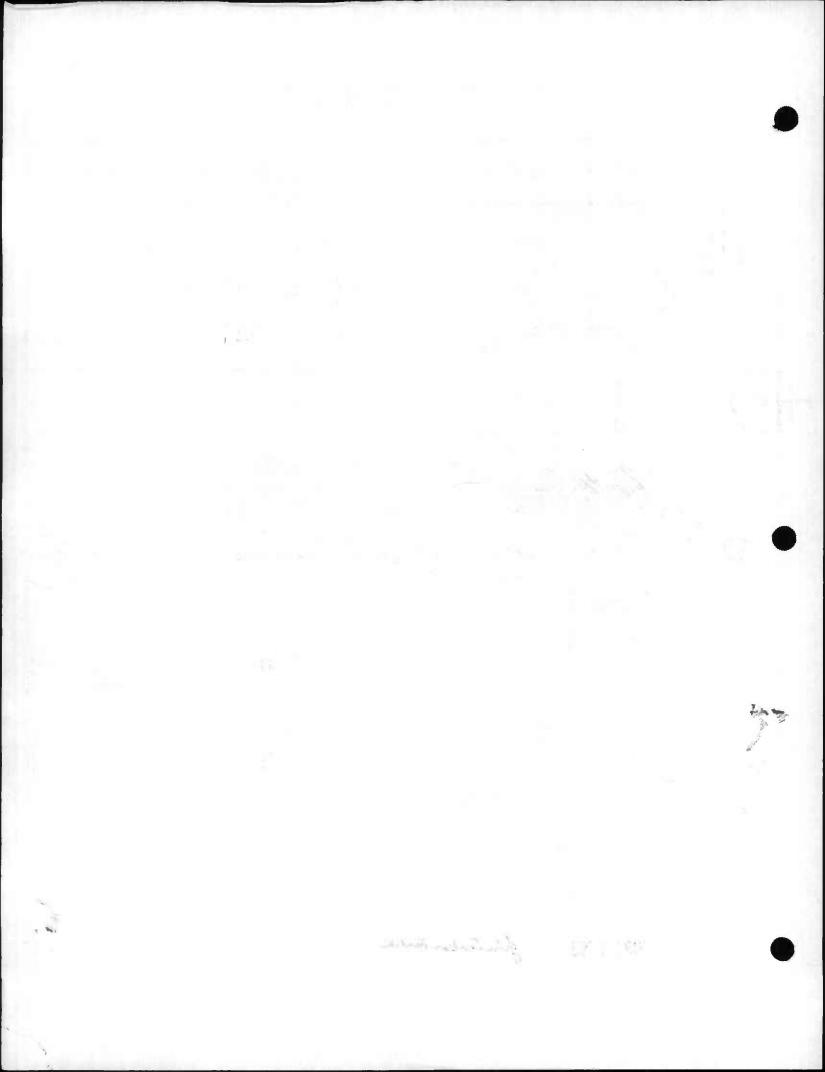
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32. REGISTRAN'S SIGNATURE
Sur LES PROPOSED

Sterling, M.D.

James A.

31. DATE FILEO (Month, Day, Year)
WAR 1 1 '93



BALTIMORE, MARYLAND 21215-0020

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A CHARLEAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained	To Direction when this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 st	
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E	崖	72 nouns after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
А	c	ž.
50	SE.	No.

	MONTH DAY YEAR										3. TIME OF DEATH		
	CLIFFORD LOYD MOON								ch 7,		YEAR	6:50	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le		IF UNDER	1 YEAR	IF UNDE	R 24 HRS.	7. DAT	E OF BIRTH		Countr	
	212-38-6574	1 🛭 M 2 🗌 F	54	YRS.					Nov	27,	1938	Mar	yland
œ	9a. FACILITY NAME (If not institution, give				9b. CITY,			ION OF D	EATH		9c. COU	NTY OF D	EATH
5	Garrett Co. Memo	orial Hosp	ital		0ak	clan	ıd		1200		G	arre	tt
DIRECTOR	10e. STATE 10b. COUN	PUNTY 10c. CI			Y, TOWN OF								10d. INSIDE CITY LIMITS?
	Maryland 100. STREET AND NUMBER	Garrett			0ak1						,		1 YES 2 ND
FUNERAL	Rt. 7 Box 520					- 1	21550					10g. CITIZEN OF WHAT COUNTRY? USA	
9	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yee or if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ MO Specify:					Yes or No	14. RACE Black Specif	- American Indian, t, White, atc.
ו נ	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind.			ECEDENT'S	USUAL OC	CUPATIO	ON		16	b. KIND OF E	BUSINESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0-12)	Conede (1-4 of 2+)			of work done during most of working use retired.)					Window			
E	11 17. FATHER'S NAME (First, Middle, Last)		Equ	птрше	nt Op	pera					Mining	g	
	Albert Manuel Mo	on						ner's na Llie		Middle, Maid		ulme	20
8	19a. INFORMANT'S NAME (Type/Print)	OII	140	N. 11.11 IN.	1000000	/Da							T
2	Darlene S. Moon			Rt. 7		52					own, State, Zip. 1. 215.		
	20a. METHOD OF DISPOSITION		20b. PLACE	ANDDATE	DE DISPOSIT	TIÓN /Na	me of		OA.		LOCATION —		we State
	1	moval from State	Pleas	ematory oco	allev	7 Ce	mete	rv	3/				ryland
	21. SIGNATURE OF FUMERAL SERVICE I	JCENSEE	4		22. N	AME AP	O ADDRE	SS OF FA	CILITY		. o . D	0	10
	spours //	Vin	M0016							me - C		d, Mo	43 d. 21550
	23. PART i. Enter the diseases, or shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. A C	t caused the de	eath. Do r	not enter t					me - C	aklano	d, Mo	d. 21550 Approximate interval Between
ERTIFICATION	IMMEDIATE CAUSE (Final disease or condition	a. Due to	t caused the dese on each line	eath. Do ree.	not enter t					me - C	aklano	d, Mo	d. 21550 Approximate interval Between
MEDICAL	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that inflitted events resulting in death) LAST	a. DUE TO (t caused the dise on each line (OR AS A CONSE	eath. Do de e.	not enter t	ferlying	da of dy	ling, suc	L.	ne - C	Dakland AN AUTOPSY ORMED?	d, Mo	d. 21550
MEDICAL	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions.	a. DUE TO (t caused the dise on each line (OR AS A CONSE	eath. Do de e.	not enter t	derlying	da of dy	given in	Part i.	24a. WAS PERF	Dakland AN AUTOPSY ORMED?	d, Mo	Approximate interval Betwoonset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da
MEDICAL	Shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other aignificant condition Caul W 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND	a. DUE TO DUE TO DUE TO DUE TO DUE TO HOSPIAL: 1 Elimentar 2	t caused tha dese on each line (OR AS A CONSE (OR AS A CONSE (OR AS A CONSE death but not i	QUENCE OF	orher t	derlying 26. PL:	g cause	given in	Part I.	24a. WAS / PERF. 1 (E) YES	AN AUTOPSY ORMED?	24b.	Approximate interval Betwo Onset and Da Onse
PHYSICIAN: MEDICAL	Shock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF OEATN 1 Natural 5 Pending	a. DUE TO (b. DUE TO (c. DUE TO (d. DONA CONTRIBUTING TO (MONTH), Da (MONTH), DA (MONTH),	t caused tha dese on each line (OR AS A CONSE (OR AS A CONSE (OR AS A CONSE death but not in the consecution of the consecu	GUENCE OF COUENCE OF C	orher t	26. PL: ing Horn	g cause	given in	Part I.	24a. WAS / PERF. 1 (E) YES	Dakland AN AUTOPSY ORMED?	24b.	Approximate interval Betwoonset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da Onset and Da
ED BY PHYSICIAN: MEDICAL	Shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other aignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF DEATN	a. DUE TO (b. DUE TO (d. DUE TO (d. DUE TO (Month, Da 28e, PLACE OF 28e,	t caused tha dese on each line (OR AS A CONSE (OR AS A CONSE (OR AS A CONSE death but not in the consecution of the consecu	GOUENCE OF COUENCE OF	OTHER:	26. PL: ing Hom WO 1 1 1	Cause of Cau	given in	Part I.	24a. WAS A PERF. 1 (B) VES	AN AUTOPSY ORMED? 2 ND	24b.	Approximate interval Betwoonset and Da Onset
COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	Shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 27. MANNER OF OEATN 1 Natural 5 Pending 1 Natural 5 Pending 2 Accident 3 Suicide 8 Could not be determined	a. DUE TO (b. DUE TO (c. DUE TO (d.)) HOSPITAL: 1 2/Inpetient 2 28e. DATE OF (Month, De 28e. PLACE Of building, d.) SICIAN: To the best of the second	t caused tha desire on each line (OR AS A CONSE (OR AS A CONSE (OR AS A CONSE death but not in ER/Outpetient 3 INJURY sy, Year) F INJURY — At hoetc. (Specify) my knowledge, de	GUENCE OF COUNCE OF COUENCE OF COUENCE OF COUENCE OF COUNCE OF COUENCE OF COUNCE OF CO	OTHER: 4 Nurshine E OF 2 2 2 3 3 4 3 4 4 4 4 4 4	2e. PL: ing Hom in in in in in in in in in in in in in i	ACE OF D ACE OF D S GREAT ACE OF D ACE OF D ACE OF D ACE OF D ACE OF D ACE OF D ACE OF D ACE OF D ACE OF D	given in	Part I. Cock only cock on	24a. WAS / PERF 1 (Specify) SCRIBE NOW CATION (Street or Town, Steet	AN AUTOPSY ORMED? 2 NO VINJURY OCC	24b.	Approximate interval Betwood Onset and Da On

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

State St.

603B W.

32. REGISTRAR'S SIGNATURE
Suha Davidson-Randes

Roger Lewis, M.D.

31. DATE FILED (Month, Day, Voer)

AAR - 9 1993

DHMH-18 Rev 1/89

Terra Alta, W. Va. 26764

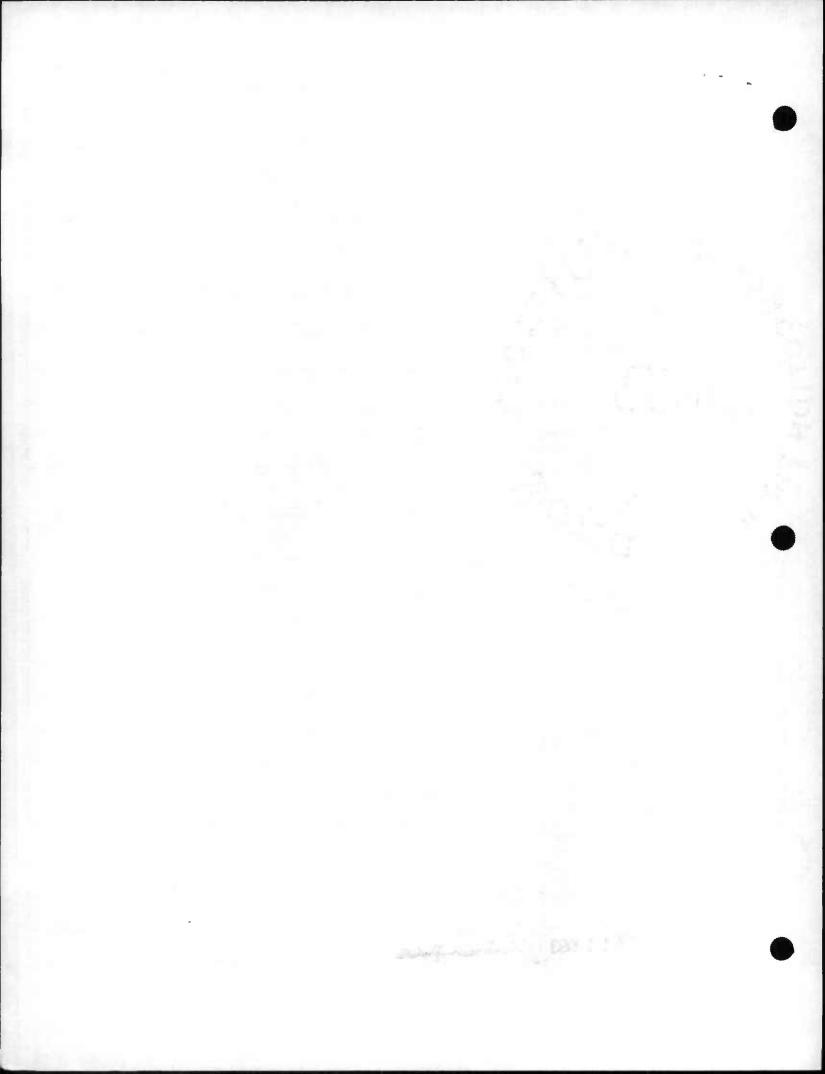
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TO THE FUNCTIAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	ENT OF H	EALTH AND DEATH		YGIENE EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D		3. T	IME OF DE	ATH
	Edward	Grant	MOON			3	9 1 C	YEAR 7:	43	ам
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday) IF	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B	IRTH	8. BIRTHPLAC	E (State or	-
	220-28-9938	1 x M 2 □ F 6		THE DAYS	HOURS MIN.	Apr. 9		Maryla		
	9a. FACILITY NAME (If not institution, give stre			CITY, TOWN (OR LOCATION OF D			TTAL Y L	DIII	
TOR	Garrett County Men				cland			arrett		
DIRECTOR	10a, STATE 10b, COUNTY	Garrett	10c. CITY, TO	OWN OR LOCAT	Oakla	and			INSIDE CIT	
	10e. STREET AND NUMBER	Jarrece		100	ZIP CODE	anu	10a CITI	ZEN OF WHAT	YES 2	
FUNERAL	Rt. 1, Box 6762					E 0	109.011		COUNTRIT	
ž		12. WAS DECEDENT EVER II	NIIS ARMED	12 WAS DEC	2 1 5 S			USA		
BY FL	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 X NO	If yes, sp	ecify Cuban, Mexica 2 X NO Specif	an, Puerto Rican,	, etc.)	14. RACE — A Black, Whi Specify:	Whit	
COMPLETED	15. DECEDENT'S EDUCA	ATION	16a. DECEDENT'S USL	AL OCCUPATION	ON .	16b. KIND	OF BUSINESS/IND	USTRY		
	(Specify only highest grade of Elementary/Secondary (0-12)	Coffege (1-4 or 6+)	(Give kind of work life. Do NOT use re	done during mo ired.)	st of working					
립	12		Carpenter	Farmer		Car	pentry/F	armino		
8	17. FATHER'S NAME (First, Middle, Last)		,				Maiden Sumame)	arming.		
	Lester Clarenc	e Moon			Goldie			T 3		
BE	19a. INFORMANT'S NAME (Type/Print)	e Moon	T 401 MAN NO 101				lvesta	Jud	У	
2							ty or Town, State, Zip			
	Harriett M. Moon				2, 0akla		_	21550		
	20e. METNOD OF DISPOSITION 1 X Burial 2 Cremation 3 Remov		PLACE AND DATE OF D		me of		20c. LOCATION (
	4 Donation 6 Other (Specify)		Eglon Ce	metery		3/12	Eglon, W	Vest Vi	rgin	ia
	21. SIGNATURE OF FUNERAL SERVICE LICE	Make /			D ADDRESS OF FA					
	P. Allo, A	Woods !			wart Fun		ome Oakland,	MD C	21550	
\neg	23. PART I. Enter the diseases, or co	molicetions that caused	the death. Do not	onter the mo	de of dving eur	th as cording	Vakiani,	, FID 2		
	shock, or heart fallure. Li	ist only one cause on e	ach line.	muer the mo	de or dying, suc	an as cerulac i	or respiratory arm	eat,	Approximinterval	
	IMMEDIATE CAUSE (Final disease or condition								Onset ar	nd Death
ı	resulting in death) a.	Hemorrhage	, Cerebral	, righ	nt				2 wee	ks
			CONSEDUENCE OF):							
Z	Sequentielly list conditions, b.	_Glioma of							Unkno	wn
Ĕ	if any, leeding to immediate	DUE TO (OR AS A	CONSEDUENCE OF):							
CERTIFICATION	CAUSE (Disease or injury									
<u> </u>	that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):							
H	resulting in deeth) LAST									
	DART II Other significant and liles									
¥	PART II. Other significent conditions	contributing to death b	ut not resulting in th	e underlying	j cause given in		WAS AN AUTOPSY PERFORMED?		ABLE PRIO	
PHYSICIAN: MEDIC						1 🗆	YES XX NO	COM	PLETION OF EATH?	
W I									YE\$ 2 [ND
<u> </u>										
Ĭ.	25. WAS CASE REFERRED TO MEDICAL			26. PL	ACE DF DEATH (Ch	neck only one)				
is		HOSPITAL:		HER:	5 🗆 Residence	6 Other (Sne	cifu)			
È	27. MANNER OF DEATH	26a, DATE OF INJURY	26b, TIME OF				E NOW INJURY OCC	UREO		_
- 4	Natural 5 Pending	(Month, Day, Year)	INJURY		RK? ES 2 NO	4.0106.80000				
E E	2 Accident Investigation	28e. PLACE OF INJURY	At homs, ferm, stree			and LOCATION	Maria and Maria	- 5 - 15 - 1		
	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spec	#(y)	, ractory, office		City or Tow	(Street and Number on, State)	or Hurai Houte I	vumber,	
COMPLET	29a. CERTIFIER Check only	AN: To the best of my know	ledge, death occurred at	the time, data	and place, and due	to the cause(s)	and manner as state	ed.		
5	one) 2 MEDICAL EXAMINER:	On the basis of examination	n and/or investigation, in	my opinion, de	eath occured at the	time, data and p	place, and due to the	s cause(s) and	manner as	stated.
	296. SIGNATURE AND TITLE OF CERTIFIER	1. 1	//		29c. LICENSE NUI					
R	Herbert of	2011	In hos	7. 1				SIGNED (Mont		
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF THE	on // /		D 0565) b	Maı	rch 10,	199	3
	Herbert H. Leigh	ton, M.D.,	ouz E. Oak	Stree	t, Oakla	ind, Mai	cyland 2	21550		
	31. DATE FILED (MOOTE Day, Year)	32. REGISTRAR'S SIGN	ATURE							
	1 1 1993	Julia Davidson	Hondell							



3. TIME OF DEATH 4:30A

SECKGES.

interval Between

24b. WERE AUTOPSY FINDINGS

OF DEATH? 1 TYES 2 NO

0

AMAILABLE PRIOR TO COMPLETION OF CAUSE

Onset and Death

Massachusetts

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

USA

Specify: White

1 TYES 2 NO

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

FOR

32. REGISTRAR'S SIGNATURE

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DHMH-18 Rev 1/89

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TO THE MICHAEL OR MINDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page (TO THE PLINE BLOOM THE CITIES, After this certificate has been signed by the attending physician and completely filled in by the funeral directions and completely filled in by the funeral directions and completely filled in by the funeral directions.	be filed within 12 flours after used with the state body, or regulation mental hydrox proxits consult, or remover, in the medical examiner in IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner in
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STATE OF MARYLAND / DEPARTMEN	NT OF HEALTH AND MI	ENTAL HYGIENE
CERTIFICAT	TE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MAR	YLAND / DEPARTM CERTIFIC			NTAL HYGIEN REG. NO		08827
	1. DECEOENT'S NAME (First, Middle, Lest)				2	DATE OF DEATH		3. TIME OF DEATH
	Gippie Dupree M	Veal					8 93	12125 PM
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday) IF	UNDER 1 YEAR	IF UNDER 24 HRS. 7	DATE OF BIRTH	8. Bif	THPLACE (State or Foreign
	213-38-9316 9a. FACILITY NAME (If not institution, give s	1 🗆 M 2 🖳 F	92 YRS.	THE DAYS	HOURS MIN.	(Month, Day, Year) 08-25-1		
<u>.</u>						" minster		arroll
ᅙ	Carroll Luthera	an village	e Health C	enter	, west	minster		alloll
<u> </u>	10a. STATE 10b. COUNT	Y	10c. CITY, T	OWN OR LOCAT	ION			10d. INSIDE CITY
# I	Maryland Car	rroll	Wes	tmins	ter			1 YES 2 NO
ا پ	10e. STREET AND NUMBER			10f	ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?
FUNERAL DIRECTOR	200 St. Luke C	ircle			21157		Unite	d States
<u> </u>	11. MARITAL STATUS	12. WAS DECEDENT EVI		13. WAS DEC	ENDENT OF HISPANIC	ORIGIN? (Specify Ya	or No.— 14. R.	ACE — American Indian, lack, Whita, etc.
	1 Never Married 2 Married	FORCES? 1 1 Y			cify Cuban, Maxican, I 2 🙀 NO Specify:	Puarto Rican, etc.)		lack, White, etc.
8	3X Widowed 4 Divorced			"	X 450			hite
	15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. DECEDENT'S USI	JAL OCCUPATION	IN et of working	16b, KINO OF BU	SINESS/INDUSTR	Y
	Elementary/Secondary (0-12)	College (1-4 or 5+)	Me. Do NOT use re	tired.)	st or working			
텔		4	House	wife		Don	estic	
COMPLET	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME	(First, Middle, Meiden	Surname)	
BEC	George Benjami	n Norton			Laura	Waller		
0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AO	DRESS (Street a	nd Number or Rural Rou	te Number, City or Tox	n, State, Zip Code;	
۲	Robert Neal_		Glenb	urn F	arm, Run	nymede	Rd, Ta	neytown, MD
	20a. METHOD OF DISPOSITION 1 1 Burlal 2 Cremation 3 Rem	ioval from State	20b. PLACE OF DISPOSITION other place)	ON (Name of cer	netery, crematory or		CATION — City o	The state of the s
- 1	4 Donation 6 Other (Specify)		Reformed				neytow	n, MD
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	. 1 .		ID ADDRESS OF FACIL			
	Queann	Wahort	Myles	Myer 91 W	s Funera illis St	, Westm	inster	, MD 21157
	23. PART i. Enter the diseeses, or ahock, or heert fellure.			enter the mo	de of dying, such	ee cardlec or reep	iratory arrest,	Approximate interval Between
	IMMEDIATE CAUSE (Finei							Onset and Death
	disease or condition resulting in death)	. 5	D575					25
		DUE TO (OR	AS A CONSEQUENCE OF):					
۲	Sequentially list conditions,	b	1	-			1	
CERTIFICATION	If any, leading to immediate	DUE TO (OR	AS A CONSEQUENCE OF):					
<u> </u>	cause. Enter UNDERLYING CAUSE (Disease or injury	C	AS A CONSEQUENCE OF):					
	that initiated events resulting in death) LAST	50E 10 (0H	AS A CONSECUENCE OF J.					
		d						
CAL	PART II. Other significant condition	ns contributing to des	th but not resulting in t	he underlyin	g cause given in Pa		AUTOPSY RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
						_ 1 _ YES		COMPLETION OF CAUSE OF DEATH?
MED								1 YES 2 NO
						_		
A	25. WAS CASE REFERRED TO MEDICAL			26. P	ACE OF DEATH (Check	k only one)		
		HOSPITAL:		THER:	e 5 🗆 Residence 6	Other (Specify)		
SIC	EXAMINER?	1 ☐ inpatient 2 ☐ ER			URY AT 2	ed. DESCRIBE HOW	INJURY OCCURE	0
HYSIC		28a. DATE OF INJI						
	1 VES 2 NO 27. MANNER OF DEATH Neturel 5 Pending			y WC	YES 2 NO			
BY PHYSICIAN:	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJI (Month, Day, You	JURY — At home, farm, stra	M 1 🗆	YES 2 NO	261. LOCATION (Street		ral Route Number,
B	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJI (Month, Day, Y	JURY — At home, farm, stra	M 1 🗆	YES 2 NO	Ref. LOCATION (Street City or Town, State		ral Route Number,
B	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined	28a. DATE OF INJ (Month, Day, Ya 28a. PLACE OF IN, building, atc.	JURY — At home, farm, stra	M 1	YES 2 NO	City or Town, State)	iral Route Number,
B	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER Check only CERTIFYING PHYS	28a. DATE OF INJ (Month, Day, Y 28a. PLACE OF IN building, atc.	JURY — At home, farm, stra (Specify)	M 1 WC	YES 2 NO	City or Town, State	nner as stated.	ral Route Number,
COMPLETED BY	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER Check only CERTIFYING PHYS	28a. DATE OF INJ (Month, Day, Yi 28e. PLACE OF IN- building, stc.	JURY — At home, farm, stra (Specify)	M 1 WC	YES 2 NO	City or Town, State the cause(a) and me	onner as stated.	se(s) and manner as stated.
BE COMPLETED BY	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined 29a. CERTIFIER (Check only One) 2 MEDICAL EXAMIN	28a. DATE OF INJ (Month, Day, Yi 28e. PLACE OF IN- building, stc.	JURY — At home, farm, stra (Specify)	M 1 WC	YES 2 NO	City or Town, State the cause(a) and me	onner as stated.	
E COMPLETED BY	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide 6 Centified 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN 29b. SIGNATURE AND TITL OF CERTIFIER	28a. DATE OF INJ (Month, Day, W 28e. PLACE OF IN building, atc.	JURY — At home, farm, stra (Specify)	M 1 et, factory, office at the time, data in my opinion, o	YES 2 NO	City or Town, State the cause(a) and me	onner as stated.	se(s) and manner as stated.

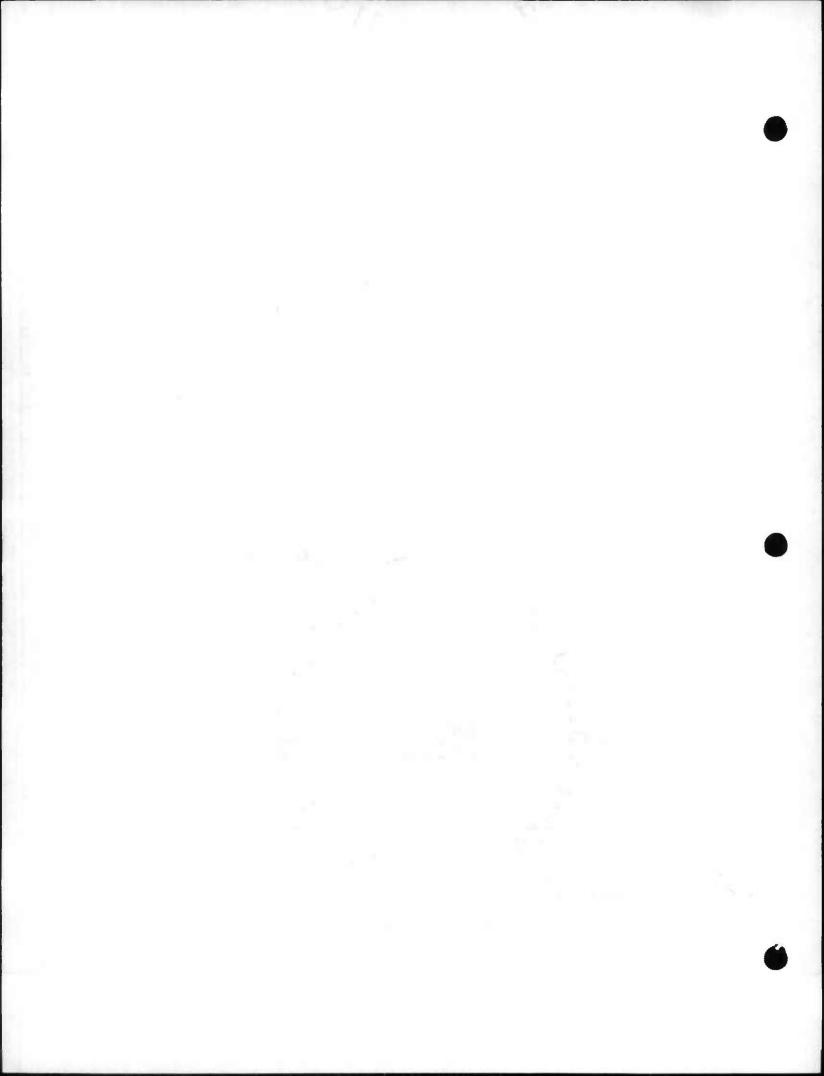
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	HE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retaine	HE RUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shou Not within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
t)		2. DATE OF DEATH

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)	=		JANE OF BEATTI	2. DATE OF DEATH	3. TIME OF DEATN		
1 8	Theresa	Μ.	Nair	n	March 4, 199	3 11:15 A M		
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. last birthday) FUNDER 1 YEAR			8. BIRTHPLACE (State or Foreign Country)		
	577-24-8062	1 □ M 2 XXF	71 YAS.	DATS HOOKS MIN.	10-3-1921	Maryland		
or .	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							
DIRECTOR	Southern Marylan	1 Center	Clinton	Pr	ince George's			
E S	10a. STATE 10b. COUNT	Υ	10c. CITY,	TOWN OR LOCATION		10d. INSIDE CITY		
		ce George	s	Temple Hills		1 TES 2 XXNO		
FUNERAL	10e. STREET AND NUMBER			101. ZIP CODE		CITIZEN OF WHAT COUNTRY?		
NE NE	4510 Simmons Lan		EVER IN U.S. ARMED	207	/48 NIC ORIGIN? (Specify Yes or No-	USA		
	1 Never Married 2 Married	FORCES? 1 IF YES, GIVE W	YES 2 NO	If yes, specify Cuben, Mexic	an, Puerto Rican, etc.)	Black, White, etc.		
) BY	3 X Widowed 4 Divorced			The same		White		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	Win Do MOT was	rk done during most of working	16b. KIND OF BUSINESS/	INDUSTRY		
PE	Elementary/Secondary (0-12) 12th	College (1-4 or 5+		istrator	Federal	Government		
OM	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S N.	AME (First, Middle, Maiden Surname			
BE C	Massimo DeM	ichele			nedetta DeDome			
TO B	19a. INFORMANT'S NAME (Type/Print)			DDRESS (Street and Number or Rural				
	Stephen Wolfsbe	rger			rfax, Virgini			
	20a. METHOD OF DISPOSITION 1 TV Burial 2 Cremation 3 Rem	oval from State	cometery, crematory or oth Cedar Hill			— City or Town, Stata		
	4 Donation 5 D Other (Specify) 21. SIGNATURE OF FAMERIAL SERVICE UN	CENTREE	Tcedar Hill			nd, Maryland		
	> 11/21 8 141	1			as Funeral Ho			
\vdash	6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate							
	ahock, or heert failure.	List only one caus	e on each line.	t enter the mode of dying, su	on as cardiac or respiratory	interval Between		
	IMMEDIATE CAUSE (Final disease or condition							
	resulting in death)	DUE TO	ON AL A CONSEQUENCE OF	N) WYCO				
Z	Sequentially list conditions, a Company was a company of the conditions of the condi							
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	ig to immediate						
FIC	CAUSE (Disease or injury that initiated events Due TO (OR AS A CONSEQUENCE OF):							
F	resulting in death) LAST							
	PART II. Other algolificant condition	a contributing to	death but not moulting in	the underlying across shore in	Carl In many			
CAL	TAIT II. Otto agrinomic condition	in contributing to	seath but not resulting in	the underlying cause given in	PERFORMED?	SY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDIC					1 TYES 2 HO	OF DEATH?		
≥ :						1 TYES 2 NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO								
YSIC	1 TES 2 NO	HOSPITAL:		OTHER: I Nursing Nome 5 Residence	6 Other (Specify)			
H	27. MANNER OF DEATN 1 Natural 5 Pending	28a. DATE OF (Month, Da	NJURY y, Year) 28b. TIME INJU	RY WORK?	28d. DESCRIBE NOW INJURY	OCCURED		
B	2 Accident Investigation	28a PLACE OF	IN HIEV At home from et	M 1 YES 2 NO				
COMPLETED	3 Suicide 4 Nomicide 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 28f. LOCATION (Street City or Town, State)				28f. LOCATION (Street and Num City or Town, State)	iber or Rural Route Number,		
9	CENTIFIER AVSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.							
M						stated. O the Cause(s) and manner as stated.		
	296. SIGNATURE AND TITLE OF CERTIFIE			29c. LICENSE NU		DATE SIGNED (Month, Day, Year)		
BE C	OKO			Dans	88	3 5 93		
일	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
	Rafix Nasr, M.D. 2431 Solomons Island Rd., Huntingtown, Md. 31. DATE FILED (Month, Dey, West) MAR 0 8 1993							
	31. DATE FILED (MORIT), Day, Year) MAR 0 8 199	32. REGISTRAI	S SIGNATURE Randa	82				
	munt 0 0 1333							

BALTIMORE, MARYLAND 21215-0020	n 24 hours after death. Page 6 may be retained by the hospital or attending physician.	EDRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	THE HIGHTIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	The control of the completely filled in by the stending physician and completely filled in by the factor to have after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IN CRIMICAL IS IS marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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	FOR STATE REGISTRAR	STATE OF MARY		TMENT OF H		MENTAL	HYGIEN REG. NO	_		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE O	OF DEATH	AV Y	EAR 3.	TIME OF DEATH
	Martha	Elean		NOGLE		3	17		13	2100 €
	4. SOCIAL SECURITY NUMBER 295-12-9099	1 🗆 M 2 💢 F	(In yrs. last birthday) 69 vrs .	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		Day, Year) 23,19		BIRTHPLA Country) hio	NCE (State or Foreign
~	9a. FACILITY NAME (If not institution, give s			9b. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNTY OF DEATH			
DIRECTOR	Washington County Hospital				Hagerstown WASH			WASH:	HINGTON	
	West Virginia Berkeley			10c. CITY, TOWN OF LOCATION Falling Waters			LIMITS		d. INSIDE CITY LIMITS?	
₹	10s. STREET AND NUMBER			101. ZIP CODE				10g. CITIZEI	OF WHA	T COUNTRY?
剪	153 Lee Lane			25419			USA			
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 NO	13. WAS DECENDENT OF HISPANIC ORIGIN If yes, specify Cuban, Mexican, Puerto I 1 YES 2 NO Specify:			GIN? (Specify Yes or No— ld. RACE — Americ Black, White, etc.) Specify: Whit.e.		hite, etc.	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		18a. DECEDENT'S (Give kind of a Me. Do NOT us	USUAL OCCUPATE work done during mo ne retired.)	ON est of working	16b.	KIND OF BU	SINESS/INDUS	TRY	
3	Eletterizary (0-12)	Conege (1-4 or 5+)	Teach	er		R	usine	ss Sch	201	
8	17. FATHER'S NAME (First, Middle, Last)		1		18. MOTHER'S NA				30 I	
BEO	John	Haskell	Murra	ıv	Mare	garet			Ot	Jav
10	19a. INFORMANT'S NAME (Type/Print) Harry A. Nogle				and Number or Flurel eshoe Bei	Route Numbe	er, City or Tow		de)	
		20	DE PLACE AND DATE	OF DISPOSITION /N	ama of	DATE	20c I O	CATION - CIN	or Town	Chata
	20e. Docation 2 Deposition 1 M Burlet 2 Cremation 3 Removal from State 4 Donatton 5 Other (Specify) 20b. PLACE AND DATE Of Disposition (Name of cemetery, crematory or other place) 5 Dother (Specify) 4 Donatton 5 Dother (Specify) 5 Donatton 5 Donat					MD	21712			
	22. NAME AND ADDRESS OF FACILITY OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport.MD 21795									
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition						Approximata Interval Between Onset and Dea			
CERTIFICATION	Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL C	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a, WAS AN PERFORM 1 YES 2				MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
2										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpatient 2 FR/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									
¥	27. MANNER OF DEATH	28a. DATE OF INJURY	26b, TIM		IURY AT			NJURY OCCUP	RED	
BY PI	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INI	M 1	PRK? YES 2 NO	Lou. DESI	- HOW I	JOHT OCCUP		
	3 Suicide 4 Homicide Could not be detarmined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28b. LOCATION (Street and Number or Rurel Route Number, City or Town, State)									
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
TO BE C						onth, Day, Year)				
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo. Print) Michael J. McComack 1799 Howell Road Baserston, MO 21740									
	31. DATE FILED (MODIF) Day, Year) MAR 15 1993 32. REGISTRAR'S SIGNATURE Authorized Property Control (Val)									



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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93 08897 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR Ulia Gertrude Nash 1993 14, 6 Mar. 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 9/22/1897 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 🗌 M 2 🎉 F 215-07-1617 YRS. Maryland Sa. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH DIRECTOR Greater Baltimore Medical Center Towson Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Baltimore Maryland Upperco 1 YES 2 KNO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21155 USA 16613 Trenton Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Çuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2. 2 NO If yes, specify Cuba 1 Never Married 2 Married Specify: Specify 3 Widowed 4 Divorced White 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEOENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 7th grade Housewife 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John C. Alban Minnie B. Rosier 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Y. Pearse 1601 Mt. Carmel Road, Upperco, Md. 21155 20e, METHOD OF DISPOSITION
1 & Burial 2 Cremation 3 Re 20b. PLACE ANO OATE OF DISPOSITION (Nama of 20c. LOCATION — City or Town, State OATE Forest Baptist Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3/17 Upperco, Maryland 22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSI 934 S. Main Street, Hampstead, Md. 21074 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Bety IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) OUE TO (O RAS A CONSEQUENCE OF ASCUD Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury QUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST GS

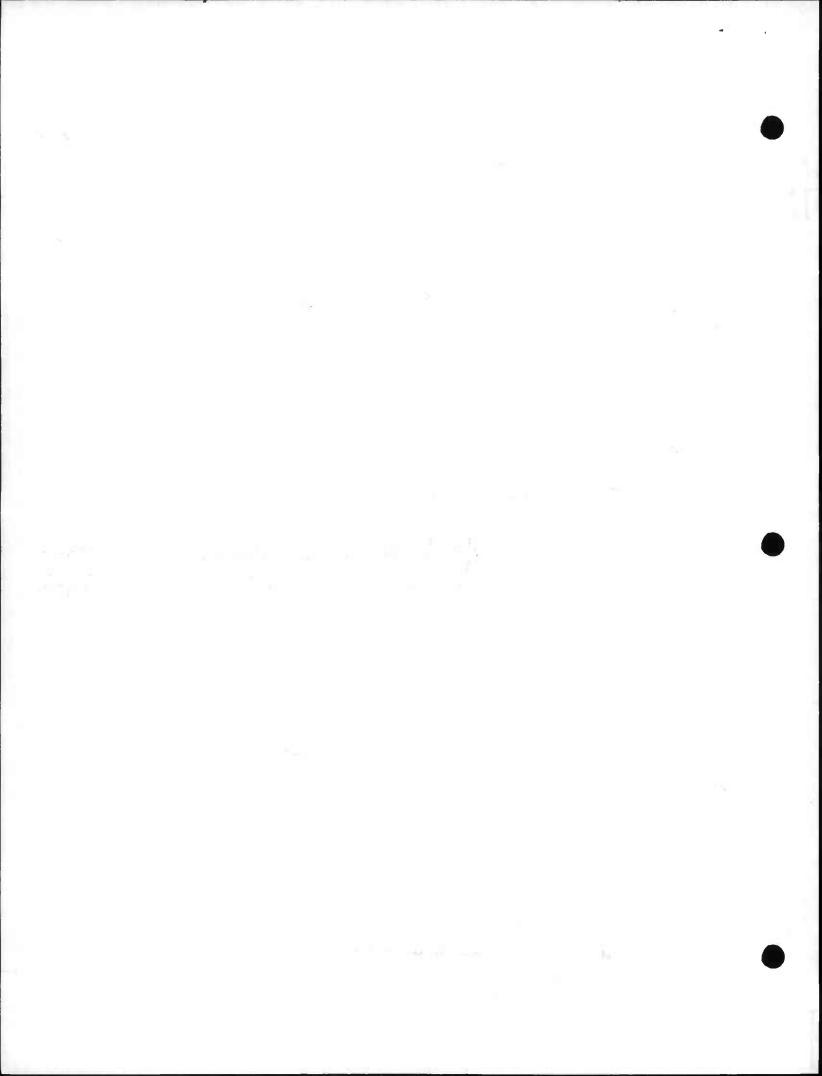
PANTIL OTHER SIGNICAL CONDUCT	s continuing to beath but not	resulting	in the t	indenying cause given ii	Part I,	24a, WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDIN MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL				26. PLACE OF OEATH (C	heck only o	O(16)		
EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpatient	3 🗆 DOA	OTHE	R: Irsing Home 5. Residence	6 🗆 Oth	ner (Specify)		
27. MANNER OF OEATH 1 Matter 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? M 1 YES 2 NO					d. DEŞCRIBE HOW INJURY OCCUREO		
3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At Inbullding, etc. (Specify)	home, ferm,	street, fa	ctory, office		CATION (Street and Number of Yor Town, State)	r Rural Route Number,	

CERTIFIER (Check only one) 2 SERIOLA CONTROL OF THE CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

carroot introdugation, in my opinion, ou	etti occured at the time, data and place	, and the to the cause(a) and manner as stated.

296. SIGNATURE 29c. LICENSE NUMBER 29d. DATE SIGNEO (Manth, Day, Year) 40

30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETEO CAUSE OF OEATH (ITEM 27) (Type, Print)
Jul Handred 1	2K thompsters up 21074
31. OATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
3/16/10 757 '93	dulie Neviden Mordell



2	sician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		
TALL MAN LAND STAN	HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	should be detached for use as the bur		ptiffled at once.
DALLIMONE, A	hours after death. Page 6 may be n	lled in by the funeral director, page 5	n, or removal.	WPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
T.C. DOY 00100,	ath certificate be executed within 24	tending physician and completely fil.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	or other traumatic event, the
VILLE RECORDS,	CIAN: The law requires that the dea	artificate has been signed by the att	he State Dept. of Health and Menta	or Item 23 shows any Injury,
TO NOTICE OF	HOSPITAL OR ATTENDING PHYSIC	THE FUNERAL DIRECTOR: After this ce	within 72 hours after death with t	TTANT: If item 28 is marked,
-	田田田	TOTHE	be filled	MPO

PETER

31. DATE FILED (MONTH, Day, Year)
WAR 1 8 '93

M.D.

VAMC PERRY POINT, MD

32. REGISTRAR'S SIGNATURE
Julia Duydson-Randare

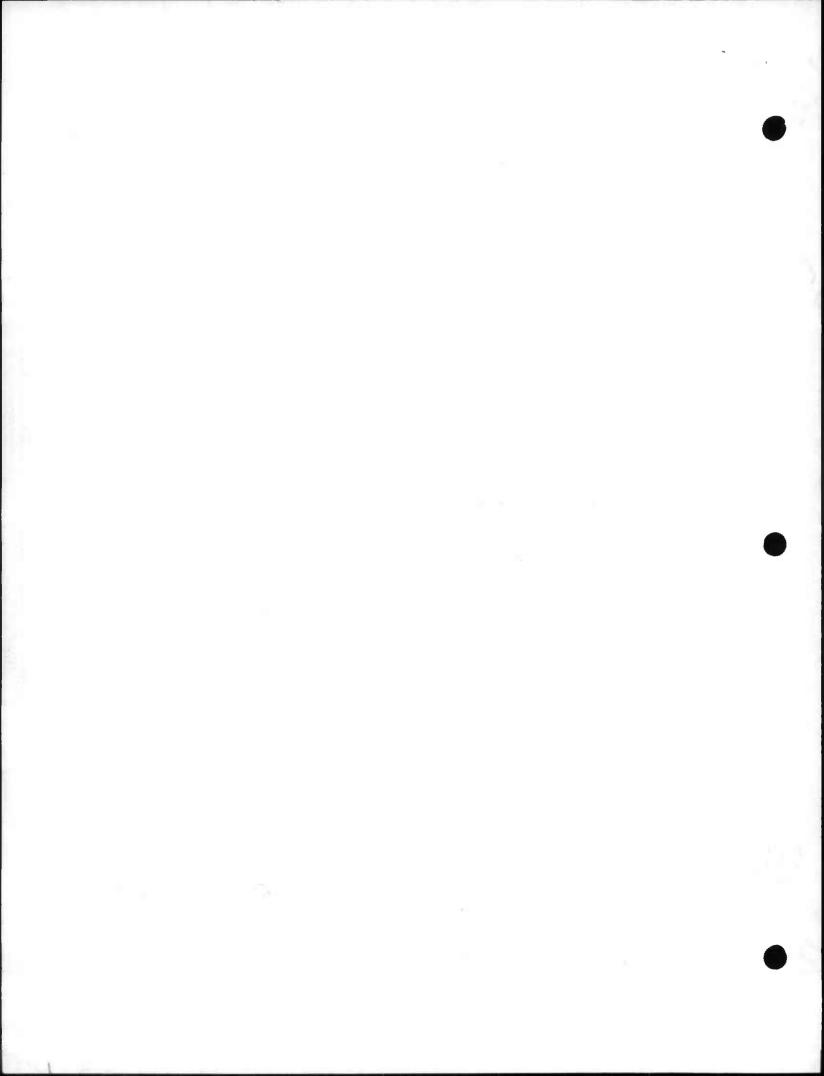
21902

											9.	3	1005	U
	1 - STATE REGISTRAR	STATE OF I			RIMENT			D MEN		GIEN				
	1. DECEDENT'S NAME (First, Middle, Last)				IOAIL	0. 0			DATE OF DE	ATH			3. TIME OF DE	ATH
	LORIN S. NELSO	LORIN S. NELSON								1.		993	9:35	# "
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs.	last birthday)	IF UNDER 1		F UNDER 24 HA	s. 7. C	ATE OF BIR			a. BIRTI	HPLACE (State or	
	212-14-4748	1 M 2 D F	78	YRS.	MONTHS	DAYS H	OURS MI		Month, Day, 1		1915	Count	m aryland	
	Se. FACILITY NAME (If not institution, give a	street and number)			96. CITY, T	OWN OR	LOCATION O			,		INTY OF D		
DIRECTOR	VA Medical Cente	er			Pe:	rry :	Point	MD				Cec	i 1	
EC	10a. STATE 10b. COUNT	Υ		10c. CI	Y, TOWN OR	LOCATION	N		10d. IN					TY
E	Maryland	Somers	et			Cri	sfield	d					LIMITS?	□ NO
AL AL	10e. STREET AND NUMBER					10f. ZI	P CODE				10g. CIT	IZEN OF	WHAT COUNTRY	7
EB	112 Somers Cove A	pts.					218:	17				U.	S.A.	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDER					DENT OF HIS				or No-	14. RAC	E — American In	dian,
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE	YES 2				ly Cuberi, Me ∭ NO Sp		erio Hican, e	4C.}		Spec		
	15. DECEDENT'S EDU	W. W.		-								l	Whi	te
ETED	(Specify only highest grade	completed)			WORK done dur		of working		16b, KIND	OF BU	SINESS/IN	DUSTRY		
1 2 1	Elementary/Secondary (0-12) Grade 8	College (1-4 or 5	+)	cocess	,				Son	F00	a			
COMPL	17. FATHER'S NAME (First, Middle, Last)		111	OCESS	OI	L	8. MOTHER'S	NAME /	Seat					_
C	Martin Luther Nel	son				1.5			Edna					
00	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (S	Street and				_		n Code)		
2	Joyce F. Nelson (Wife)			me as						.,			
	20s. METHOD OF DISPOSITION 1X Burlel 2 Cremation 3 Rem	oval from State	20b. PLAC	E AND DATE	OF DISPOSITI	ON (Name	of		DATE 2	0c. LO	CATION -	City or To	own, State	
	4 Donation 5 Other (Specify)		st.	eters	cher place) Churc					Cri	sfie	ld, ì	MD @	
	21. SIGNATURE DE PUBERAL SERVICE LA	DENSEE	//				ADDRESS OF			222	1 Uor	200		
	Robert H. Bra	dshaw, J	2.				. Mair						2181	7
	23. PART I. Enter the diseases, or shock, or heart failure.	complications the	t caused the	death. Do	not enter th	ne mode	of dying,	such as	cardiac or	respi	iratory ar	rest,	Approxi	mate
	iMMEDIATE CAUSE (Final	List only-one car	use on each II	ine.										Between nd Death
	disease or condition resulting in desth)	Chronic	obstr	uctiv	e Puln	nonar	y Dis	sease	3					
	,	DUE TO	(OR AS A CONS	SEQUENCE C	NF):	_	-							
Z	Sequentially list conditions,	Atheros				scul	Lar Di	seas	se					
RTIFICATION	if any, leading to immediate	DUE TO	(OR AS A CONS	SEQUENCE C	NF):									
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	C. DUE TO	(OR AS A CONS	DECLIENCE C	MP1.									
Ē	that initiated events resulting in death) LAST	DUE TO	(OH AS A CONS	SECULENCE C	-):								İ	
崽		d											-	
- 1	PART II. Other significant condition	a contributing to	death but no	t resulting	in the unde	erlying c	ause given	in Part			AUTOPSY	244	. WERE AUTOPSY	
MEDICAL											MED?		COMPLETION O OF DEATH?	
Ä													1 YES 2] NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQSPITAL:			07115	26. PLAC	E OF DEATH	(Check or	nly one)					
YSI	1 TYES 2 XXV	1 2 Inpatient 2	☐ ER/Outpatient	3 🗆 DOA	OTHER: 4 Nursin	g Home	5 🗆 Residen	ce 6 🗆	Other (Speci	fy)				
27. MANNER OF DEATH 27. MANNER OF DEATH 28. DATE OF INJURY (Morth, Day, Year) 28. TIME OF INJURY AT WORK? 1 YES 2 NO 28. PLACE OF INJURY — At home, farm, street, factory, office 28. PLACE OF INJURY — At home, farm, street, factory, office 28. LOCATION (Street and Number or Rural Route Number)														
							David March .							
윤	3 Suicide 6 Could not be 4 Homicide determined	building	etc. (Specify)	monne, termi,	ationt, lactor	y, other		201.	City or Town			r or norm	Hodie Number,	
LET	29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	CIAN: To the hert -	I my knowledge	doub	and at the A	a data a	d alaa 1	A. 4 P.		-i -	1-	4.5		
COMPL	(Check only one) 2 MEDICAL EXAMINE												s) and manner =	stated
- 1	296. SIGNATURE AND TIDES OF CONTINUE				,				p	,				
B	7/7/5	4		ds	25	3	LICENSE	S S	77	>	PHI. DAT	SIGNE	130	>
유	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CA	SE OF DEATH (I	TEM 27) (No	Print	1	100					10	16	_

Ti ----

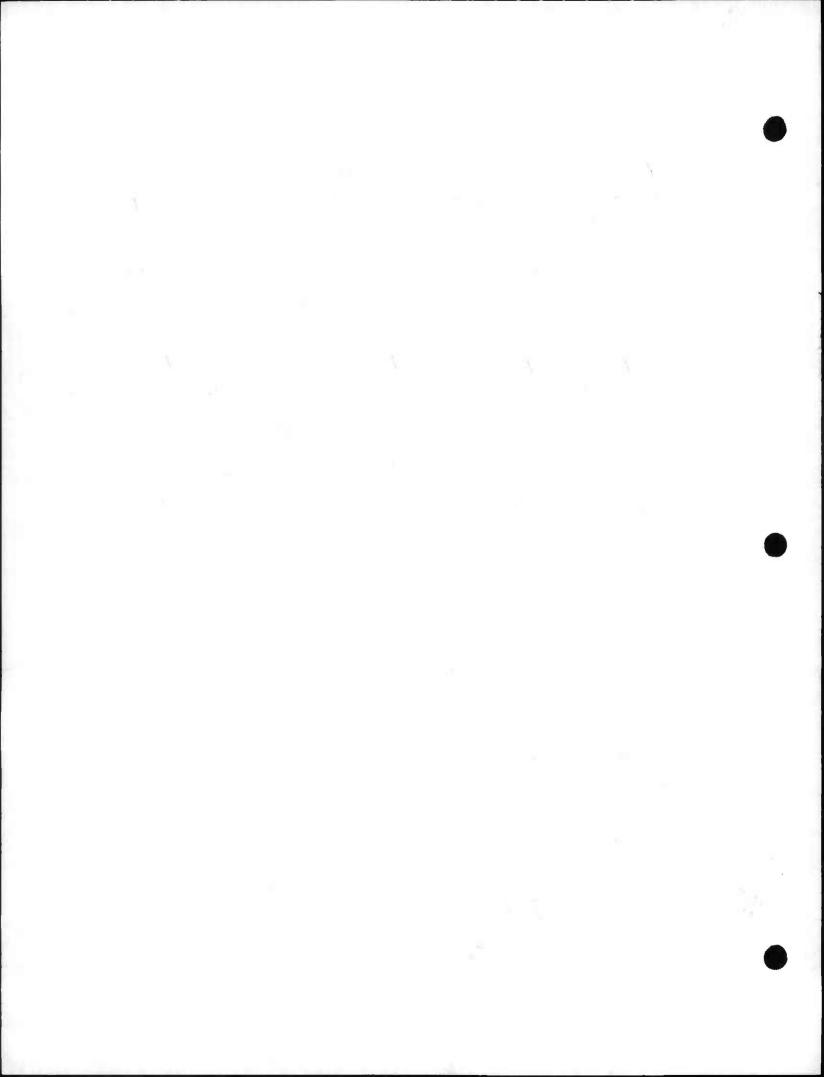
age 6 may be retained by the hospital or attending physi	director, page 5 should be detached for use as the burta		er must be notified at once.
TO THE HOST BLANK ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physic	TO THE PROCESS. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burla	be fined within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If them 28 is marked, or flem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR		OTATE OF I	6 6 DV4 6 0	ID / DEDIE						9	3 (18899
	1 - STATE REGISTRAR		SIAIE UF I	MAHYLAN	CERTIF				MEN	TAL HYGIEN REG. NO.	E		
100	1. DECEDENT'S NAME (First,	14	STINA	0	wine	-5			2.0	ATE OF DEATH DA	'' (YEAR G3	3. TIME OF DEATH 3.45A M
	2/7-36-4	365	5. SEX		rs. lest birthday) 86 YRS.	IF UNDER 1 YE	AR IF UN	IDER 24 HRS.	(A	7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Fore Country))
	Sa. FACILITY NAME (If not in	estitution, give s			80	9b. CITY, TO	WN OR LOC	ATION OF D		14-26-0		Mar NTY OF DE	yland ATH
TOR	2526 Salem Bottom Rd.					Westminster Carroll						11	
2526 Salem Bottom Rd. Westminster RESIDENCE OF DECEDENT 100. STATE 100. COUNTY Maryland Carroll Westminster Westminster											10d, INSIDE CITY LIMITS?		
	Maryland 100. STREET AND NUMBER	Ca	rroll		We	stmin	ster	-					1 TYES 2 NO
FUNERAL	2526 Salem	Bott	om Road	i E				2115°	7				States
	11. MARITAL STATUS 1 🔀 Never Married 2	-	12. WAS DECEDEN	T EVER IN U.	S. ARMED	13. WAS	DECENDEN	IT OF HISPA	NIC OF	IIGIN? (Specify Yes			- American Indian,
B	3 Widowed 4 Divo		IF YES, GIVE V					NO Specif		, to raceit, ecc.,		Specif	
ETED	(Specify only	EDENT'S EDUC y highest grade	CATION completed)	18	Give kind of life. Do NOT u	work done durin		orking	1	16b. KIND OF BUS	HNESS/IN	DUSTRY	
APLE	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)		naker				Do	mes	tic	
COMPL	17. FATHER'S NAME (First, M						18. M			rst, Middle, Maiden			
B	Richard E		wings		19b. MAILING	ADDRESS (St	reet and Nun			Eliza Vumber, City or Town			1f
2	Leroy Chr	onist	er										r, MD21157
	20a, METHOD OF DISPOSITE 1 To Burlet 2 Cremation 4 Donation 5 Other	n 3 🗆 Rame	oval from State	cemeter	ACE AND DATE	ther place)			13	3/191		City or Tov	
	21. SIGNATURE OF FUNERA		ENSEE	- Hrin	iity Lu	22. NAB	E AND ADD	PRESS OF FA	CILITY	'	tmin	ster,	Maryland
	Sugar	ext	-Only Os	tit	1/184	-				. Home Westm	ieni	tor.	MD 21157
	23. PART I. Enter the di shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	aart fallure.	complications the	t caused the	ne death. Do	not enter the	mode of	dying, suc	h as	cardisc or respi	ratory ar	rest,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentisity list condition of any, leading to immecause. Enter UNDERLY! CAUSE (Disease or injustat initiated events resulting in death) LAS	diate ING Iry	DUE TO DUE TO DUE TO SU	fem OR AS A CO	ONSEQUENCE OF THE CONSEQUENCE OF	PRA	enal Pehy.	Trat	7^	خــــــــــــــــــــــــــــــــــــ			
MEDICAL	PART II. Other significa	nt condition	s contributing to	desth but	not resulting	in the under	lying caus	se given in	Part	24a. WAS AN PERFOR	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:			OTHER:		F DEATH (C)					
	1 VES 2 NO 27. MANNER OF DEATH		1 Inpatient 2 28a. DATE OF	INJURY	28b. TIM		. INJURY AT		_	Other (Specify) DESCRIBE HOW IF	NJURY OC	CURED	
10		Pending Investigation				M 1	WORK?	2 ND					
ا د		Could not be determined	28a. PLACE O building,	F INJURY — etc. (Specify)	At home, farm,	street, factory,	office		28f.	LOCATION (Street a City or Town, State)	nd Numbe	r or Aurel Ro	oule Number,
COMPLEIE	29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowledg	ge, death occurr	ed at the time,	data and pl	ace, and due	to the	cause(a) and men	mer as sta	ted.	
200	The same of the sa	THE RESIDENCE OF THE PARTY OF T		kamination ar	nd/or Investigation	n, in my opini	on, death oc	cured at the	time,	data and place, and	d due to ti	ne cause(a)	and manner as stated.
20 01	30. NAME AND ADDRESS OF	2//	mes!	SE OF DEATH	(ITEM 27) (Type	Print)	290.	D4	MBER 27	18	29d. DAT	E SIGNED	(Month, Day, Year) (PLH 16, 93
	Dean H. G	riffi	,				stmi	nste	c,	MD 2	115	7	
	31. DATE FILED (Month, Day,	8 '93	32. REGISTRA	R'S SIGNATU	e Roa	JIA.							



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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) +win 3. TIME OF DEATH PASY GRIFFIN March 12 PM 1993 ORTIZ 8:47 MAHIEU 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign **XX**M 2 □ F YRS. 03 Maryland 10. 1993 use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH sity of Maryland Hospital DIRECTOR Baltimore N/A 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Anne Arundel Crofton 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY 1740 Fallsway Drive 21114 United States 24 hours after death. Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 27 THO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 VES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. XX Never Married 2 - Married В 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A n/a n/a 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Carlos Ortiz Shawn Mahieu 19a. INFORMANT'S NAME (Type/Print) 2 Carlos Ortiz 1740 Fallsway Drive Crofton, Maryland 21114 e e 20a. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 1 Burlei 2 Tycremation 3 Removal fr Lincoln Crematory 03-21-93 Brentwood, Maryland examiner 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD attending physician and completely filled In by the offen Hygiene prior to burial, cremation, or removal. medical 29. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate ahock, or heart feliure. List only one ceuse on each line. interval Between IMMEDIATE CAUSE (Finel Onset and Death event, the disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE, OF): DUE TO (OR AS A CONSEQUENCE OF): executed Mental Hygiene prior to burial. traumatic CERTIFICATION Sequentially list conditions. if any, leading to immediate death certificate be Caaquilo pathe
DUE TO (ORLS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST 10 certificate has been signed by the h the State Dept. of Health and Mer PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? law requires that the 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE shows any 1 TES 2 NO 1 TES 2 NO 23 8 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? item ; 26. PLACE OF DEATH (Check only one) HOSPITAL:
1) Inpetient 2 ER/Outpetient 3 DOA OTHER: 1 TES 2 NO PITAL OR ATTENDING PHYSICIAN: 4 Nursing Home 5 Residence 8 Other (Specify) the ŏ 27. MANNER OF DEATH 26e. DATE OF INJURY 28c. INJURY AT WORK? 28d DESCRIBE HOW INJURY OCCURED 28 is marked, FLERAL DIRECTOR: After this of 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — Al home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number City or Town, State) 6 Could not be datermined COMPLETED 4 Homicide if item 29e. CERTIFIER (Check only Indicated in the control of the control 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and menner se stated. MPORTANT 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 2 T 1 S BE eu Jmis P4417 3/12/ 9 3 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kevin M 24 wher MO 2120 22. J. Greene 32. REGISTRAR'S SIGNATURE 12MAR 16 1993 Julia Davidson Randale



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

VG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	th the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
law requires that the death certificate be exec	has been signed by the attending physician and	Dept. of Health and Mental Hygiene prior to bu	23 shows any injury, or other traumati
TOTTHE HOSPITAL OR ATTENDING PHYSICIAN: The	TO THE FUNERAL DIRECTOR: After this certificate h	be filed within 72 hours after death with the State	IMPORTANT: If Item 28 is marked, or item

	FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYG				
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEAT	TH .	3. TIME OF DEATH		
	Kenneth M.	O'Neill				03	13 1	993 4:05 PM		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTI (Month, Day, Ye.	4 8	BIRTHPLACE (State or Foreign Country)		
	218-28-1403	1 × × 2 □ F 62	7 YRS.		E J-101 Jayrie	04 28	1930	Maryland		
Œ	9a. FACILITY NAME (If not institution, give s	treet and number)		9b. CITY, TOWN D		EATH	100 - 300 12	Y OF DEATH		
DIRECTOR	8 Peale Court RESIDENCE OF DECEDENT		1	Anno	apolis		Anne	2 Arundel		
REC	10a. STATE 10b. COUNT	e Arundel	10c. CITY,	TOWN OR LOCATE				10d. INSIDE CITY LIMITS?		
	10a. STREET AND NUMBER	e runaec		Annapo				1)(X) YES 2 ND		
FUNERAL	8 Peale Court			10f.	21403			n of what country? ted States		
N N	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DECE		NIC DRIGIN? (Specif				
BY F	1 Never Merried 2 Married 3 Widowed 4 Divorced	FDRCES? YES	2 NO	If yes, spe	city Cuban, Mexico	an, Puerto Rican, ato	٤.)	I. RACE — American Indian, Black, White, etc. Specify;		
		Korean						White		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	(Give kind of wo life. Do NOT use	ork done during mos	N t of working	16b. KIND O	F BUSINESS/INDUS	STRY		
집	Elementary/Secondary (0-12)	College (1-4 or 5+)	Manage	r - Tra	ining	1	wra Sto	70		
Š	17. FATHER'S NAME (First, Middle, Lest)		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ME (First, Middle, Mi				
BE	John P. O'Neill				Mabel	I. Morel	and			
2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City o				
	Mary P. O'Neill					polis, M				
	Buriel 2 Cremation 3 Rem	oval from State 20b.	PLACE AND DATE DE Pery, commetory or oth Sames	enlace) ('Emotori	ne of		LOCATION - CR	y or Town, State , Maryland		
1	21, SIGNATURE OF FUNERAL SERVICE LIC	enfee /	punes	22. NAME ANI	D AODRESS OF FA	CILITY				
1	to trulalla	1. 4. the		117 0		John	M. Taylo	or Funeral Home		
	23. PART i. Enter the diseasea, or	complications that caused	the deeth. Do no	t enter the mod	le of dving, suc	touceste	ス S.T. Al	napolis, MD		
	shock, or heart failure. iMMEDIATE CAUSE (Finel	List only one cause on ec	och line.					interval Between Onset and Death		
	disease or condition resulting in death)	disease or condition								
								May),		
NO NO	Sequentially liet conditions,		CONSEDUENCE OF							
CAT	If any, leading to immediate cause. Enter UNDERLYING	.0.0	421)1-	EVA				10/4/11		
THE	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF)							
CERTIFICATION	resulting in death) LAST	d								
AL 0	PART il. Other significant condition	e contributing to deeth be	ut not reculting in	the underlying	ceuse given in		S AN AUTOPSY	24b. WERE AUTOPSY FINDINGS		
SC							REDRIMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
ME							XX	1 YES 2 NO		
ž										
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:	ACE OF OEATH (Ch					
HYS	27. MANNER OF DEATH	t inpatient 2 ER/Outp	28b. TIME	OF 28c, INJU		6 Other (Specify)	OW INJURY OCCU	RED.		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	RY WOR						
	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, atc. (Speci	— At home, ferm, str	eet, factory, office		28f. LOCATION (SI City or Town, S	reet and Number or State)	Rural Route Number,		
COMPLETED	4 Homicide determined									
MPL		CIAN: To the best of my knowl								
8		-	and/or investigation,	In my opinion, de	ath occured at the	time, date end plac	e, end due to the o	cause(a) and manner as stated.		
品	296. SIGNATURE AND TITLE OF CERTIFIES	(Mir-	_		29c. LICENSE NUI			IGNED (Month, Day, Year)		
TO BE	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type F	Print)	D3118	8	Mau	ich 15, 1993		
	Richard Colgan, M	D 600 Ride 32 REGISTRAR'S SIGN 3 Julia Davidson	ley Avon	ue #120	Annanal	is Mn o	1401			
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S SIGNA	TUBE 1.00	120	ranapor	NIV Z	, 701			
	MAR 1 6 199	3 Julia Davidsor	- Harlan							

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OR ATTENI DIRECTOR: hours after Item 28 is												
	COMPLET	29e. CERTIFIER (Check only	IAN: To the best of my know	ledge, death occi	irred at the	time, date	end place, and due	to the ca	use(s) and men	ner as stated.		
12.2	No.		On the basis of examination								ause(s) en	d menner as stated.
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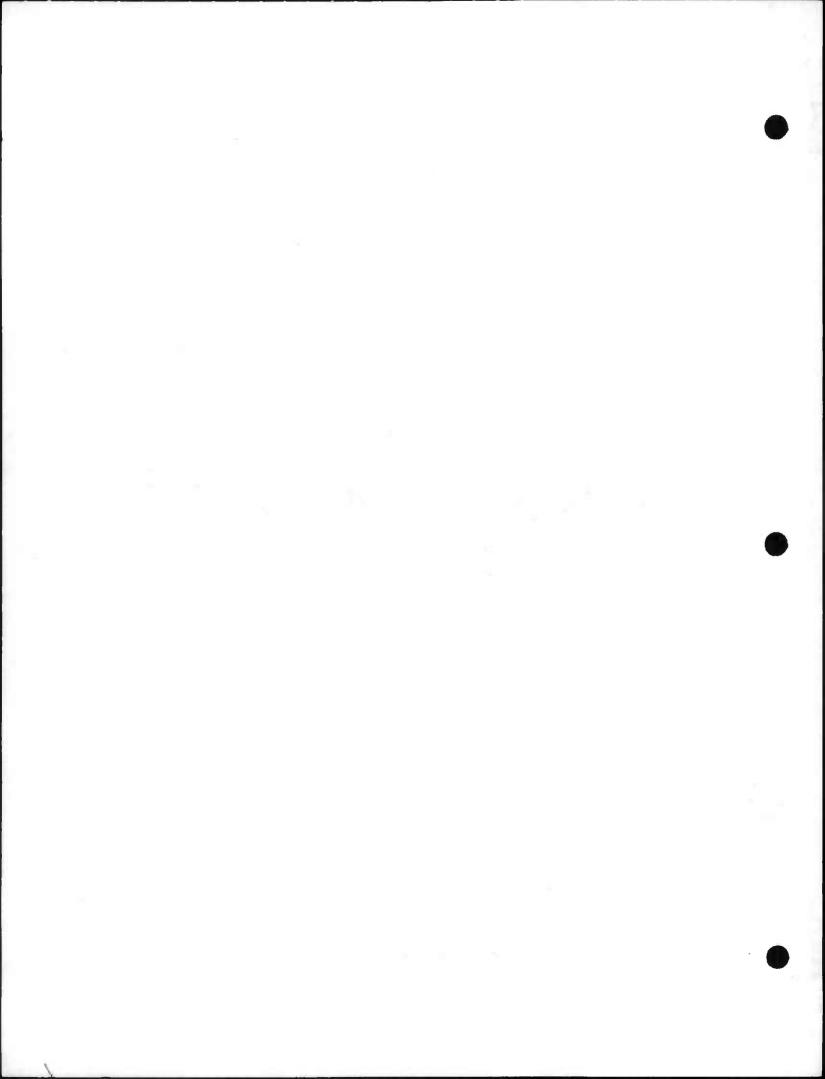
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Pages 1, 2, 3 should

93 08903 FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 8:52AM 3 -Anna L. Patterson 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreig Country) 1 🗌 M 2 🔀 F DAYS HOURS 74 YRS. 175-14-7598 4-3-18 Pennsylvania 9e. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH sou theon DIRECTO Clinton Prince George's RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Prince George's 1 YES 2 X NO Forestville FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 3006 Viceroy Avenue 20747 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES BY 1 YES 2 NO Specify: Specify: 3 Wildowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Prince George's County Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education 10 Cafeteria Worker 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ulysses DiAndreth Salvatora Scott BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Edward D. Patterson 10229 Owen Brown Rd., Columbia, Md. 21044 20a. METHOD OF DISPOSITION
1 ☐ Burial ② ★★Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION /Name of DATE 20c. LOCATION - City or Town, State 4 Donation 5 Other (Specify) Lee Crematory 3-11-93 Clinton, Md. 21. SIGNATURE OF JUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ehock, or heert fellure. Liet only one ceuse on each line. Approximate Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition Incep resulting in death) DUE TO (OR AS A CONSEQUENCE OF) 0 1 0 MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 - NO 1 - YES 2 - NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER: 1 | YES 2 | NO etient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Netural В 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29s. CERTIFIER 1 DERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the ninstion and/or infestigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296, SIGNATURE AND TITLE OF CERTIFIER BE Michael 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D24945 MANCH 811993

Dr. Levine ,M.D.,7801 Old Branch Ave., #409, Clinton, Md. 20735 32. REGISTRAR'S SIGNATURE year, 1993

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



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	FOR STATE REGISTRAR		STATE OF N					EALTH AND	MENTA	L HYGIEN	E 9	3	08904
	1. DECEDENT'S NAME (FIRST	Middle, Legel	M.	Per	ler				2. DATE	OF DEATH	9:	3 YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 579-72-4809	9 1	5. SEX	6. AGE (In yrs. I	est birthday) YRS.	IF UNDER 1 Y	YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.		OF BIRTH th, Day, Year)		Count	HPLACE (State or Foreign ory) rth Carolina
TOR HOT	90. FACILITY NAME (If not ins ANDREW AIR RESIDENCE OF DEC	FORCE		SPITAL			city, town on Location of Death uitland sc. county of Death Prince George						
DIRECTOR	MD Prince George					y, TOWN OR						10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	6513 Gatewa	ay Blvd	l.				101.	ZIP CODE 20747			USA		WHAT COUNTRY?
à	1 Never Married 2 🛣	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN FORCES? 1 VES IF YES, GIVE WAR OR DATE.				lf y	es, spe	elfy Cuben, Mexica 2 NO Specifi	nn, Puerto ly:	Y? (Specify Yes Rican, etc.)	or No—	14. RACI Blac Spec	E — American Indian, k, White, etc. ify: Black
LETED		EDENT'S EDUCAT highest grade cor)	DECEDENT'S 'Give kind of v fe. Do NOT us Lousev		UPATIO	N It of working		. KIND OF BUS	INESS/IN	DUSTRY	
E COMPLET	17. FATHER'S NAME (First, Mic	_			lousew	viie .		18. MOTHER'S NA	AME (First,				
TO BE	19a. INFORMANT'S NAME (Ty) George Per	pe/Print)						ad Number or Rural	Route Num	ber, City or Town	n, State, Zij	2074	47
	20a. METHOD OF DISPOSITION 1 K Buriel 2 Cremation 4 Donation 5 Other	n 3 🗆 Remove (Specify)	ONE STREET	20b. PLACI cemetery, c Harmo	rematory or or on Me	ther place)	rk			20c. LO		City or To	
	21. SIGNATURE OF FUNERAL	919	iff	in		Fr 38	azi	er's Fu Chode Is	nera l <i>a</i> nd	Ave	N.W		
HILICATION	iMMEDIATE CAUSE (Find disease or condition resulting in death) Sequentially list condition from the first condition from	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING S. DIA DELLO CLYT SUND NO UNTRE CELLALIVE CAUSE OF SEQUENCE OF SEQ											
PHYSICIAN: MEDICAL CERII	PART II. Office algorifican	d		death but not	resulting i	in the unde	ertying	cause given in	Part I.	24a. WAS AN PERFOR 1 YES 2	MED?	24b	. WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
SICIA	25. WAS CASE BEFERRED TO EXAMINER? 1 YES 2 NO	H	IOSPITAL:	ER/Outpetlant	3 □ DOA	OTHER:		S Residence					
ВУ РНУ	27. MANNER OF DEATH 1 Netural 5 P		26a. OATE OF (Month, De	INJURY	26b. TIMI	E OF 26 URY	Bc. INJU WOR	IRY AT		SCRIBE HOW IN	JURY OC	CURED	
	3 Suicide 6 C 4 Homicide de	Could not be	26e. PLACE Of building,	F INJURY — At It etc. (Specify)	At home, farm, street, factory, office			26f. LOCATION (Street and Number or Rural Floute Number, City or Town, State)				Route Number,	
COMPLEIED	one) 2 MEDIC	CAL EXAMINER: 0						and place, and dua ath occured at the					i) and menner as stated.
O BE	29b. SIGNATURE AND TITLE (30. JEANE AND ADDRESS OF	PA	diffe	u/M	20	2		299 NICENSE NUM	MBER 23	D	29d. DAT	E SIGNED	(Month, Day, Year)
	31. DATE FILED (Month, Day, W	Roch	11 lina	2 //	250	27 Ra	46	rum b	1.0	Sm.	M	220	748
	MAR 1 1 1993	Grish	a nantazar	Marian					•	V			

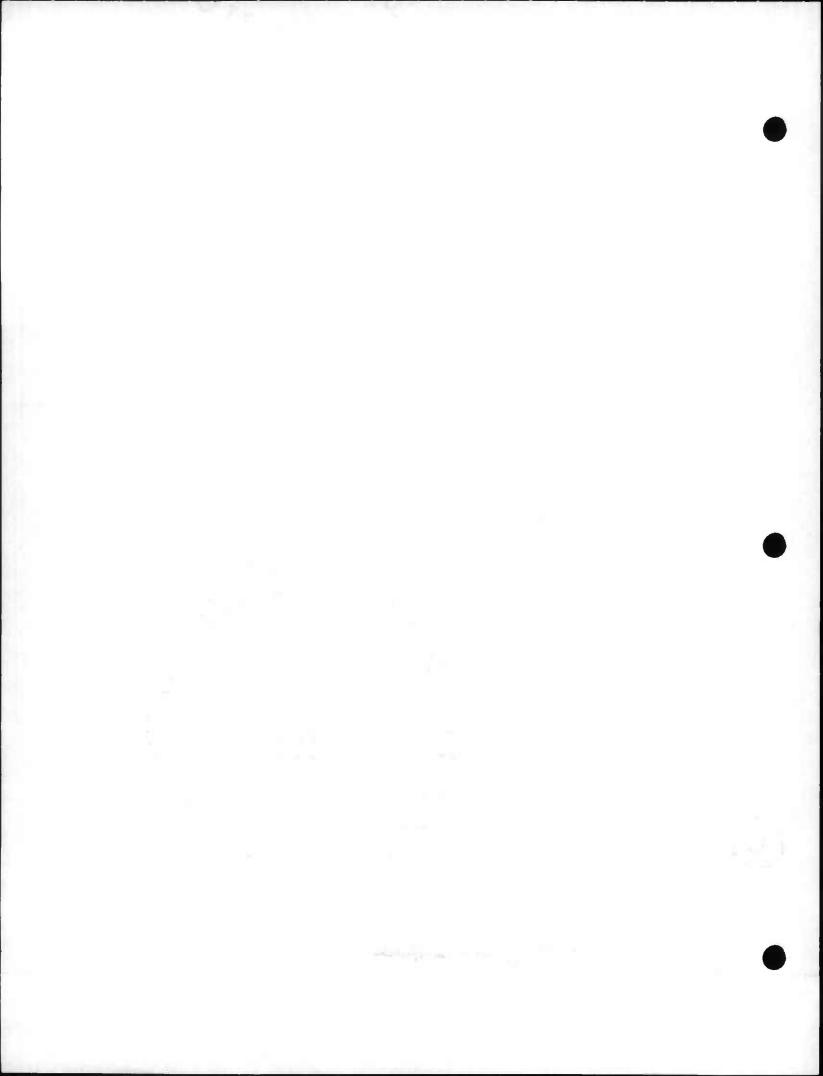
A TEMBING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

In the third that the this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **BALTIMORE, MARYLAND 21215-0020** ISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE PER TO THE Be fied IMPORTATION

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			OATE O	F DEATH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Lest PATRICIA		GE			2. DATE OF DEATH DO FEB. 2		3. TIME OF DEATH 8:25 a.m	
	4. SOCIAL SECURITY NUMBER 214-16-2388	1 🗆 M 2 🕇 F	(In yrs. lest birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) 1/8/1928	8.8	SHRTHPLACE (State or Foreign Country) MD.	
FOR	9a. FACILITY NAME (II not institution, give Frederick Memori				erick	ATH	sc. county Frede		
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUN								
DIRECTOR	Md. Fr	ederick		10c. CITY, TOWN OR LOCATION Frederick			10d. [X(X)		
FUNERAL	100. STREET AND NUMBER 517 Wilson Place	e			21702		109. CITIZEN USA	OF WHAT COUNTRY?	
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 XXWidowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 XNO	If yes,	ECENDENT OF HISPAN specify Cuben, Mexica ES 2/2/NO Specify			RACE — American Indian, Black, White, etc. Specify: White	
	15. DECEDENT'S ED	UCATION	16a. DECEDENT'S	USUAL OCCUPA	LION	16b. KIND OF BU	NESS/INITY IST	EV .	
COMPLETED	(Specify only highest grad	College (1-4 or 5+)	(Give kind of w life. Do NOT us teacher	vork done during a retired.)	most of working			 ication	
Σ					1			e con con	
BE CO	17. FATHER'S NAME (First, Middle, Last) George F. Masson	1			and the second s	me (First, Middle, Meiden eth Neal	Surname)		
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	snd Number or Rural F	Route Number, City or Tow	n, State, Zip Cod	Md. 21702	
5	Edward N. Page		Blda.	H A	ot. 113.	Country Hi	RR Ant	., Frederick	
	20s. METHOD OF DISPOSITION	20	b. PLACE AND DATED			DATE 20c. LO	OC TIPICA	- Treaterica	
	1 Donation 5 Other (Specify)	movel from State	metery, gremetory or of Muths burg	Crema	tory 2/	24/93 S	mithsbu	vig. Md.	
	21. SIGNATURE OF FUNERAL SERVICE L	Lanne		Sto	and adoress of far	neral Home Maryland 2	P.O.	Box 1819	
	23. PART I. Enter the diseases, or ahock, or heart failure iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Due to lor As	each line.		noda of dying, such	h as cardiac or respi	ratory arrest,	Approximate interval Between Onset and Death	
MOIT	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING								
1 2 1									
RTIF	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (DR AS						į	
CERTIFICATION	that initiated events resulting in death) LAST	d							
	that initiated events	d	but not resulting i	n the underly	ing cause given in	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS MALLABLE PRIOR TO COMPLETION OF CAUSE	
MEDICAL	PART II. Other significant condition	ons contributing to death	3 00	n the underly	ing cause given in	Part i. 24a. WAS AN PERFOR	MED?	AMAILABLE PRIOR TO	
MEDICAL	PART II. Other significant condition Our of or or or or or or or or or or or or or	ons contributing to death	3 00			PERFOR	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
MEDICAL	PART II. Other significant condition	d. ons contributing to death ons contributing to death ons contributing to death	3 00	26.	ing cause given in	PERFOR	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
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ED BY PHYSICIAN: MEDICAL	PART II. Other significant condition PART II. Other significant condi	HOSPITAL: 11 Inpatient 2 ER/Out 28s. DATE OF INJURY (Month, Day, Veer) 28s. PLACE OF INJURY building, stc. (Sp	potient 3 DOA 28b. TiMi INJ Y — At home, farm, a	26. OTHER: 4 Nursing H E OF 26c. I URY M 1 Street, factory, of	PLACE OF DEATH (Chome 5 Residence NJURY AT YORK? YES 2 NO	PERFOR 1 VES 2 3ck only one) 8 Other (Specify) 28d. DESCRIBE HOW I City or lown, State) to the cause(e) and mai	NJURY OCCURE	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY 1 VES 2 NO Note: The control of the control of	
COMPLETED BY PHYSICIAN: MEDICAL	that initiated events resulting in death) LAST PART II. Other significant condition O O O O O O O 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Initiation of Death 1 Ves 2 No Could not be determined 2 Accident Investigation of the determined 29a. CERTIFIER (Check only One) 2 MEDICAL EXAMIN	d	potient 3 DOA 28b. TiMi INJ Y — At home, farm, a	26. OTHER: 4 Nursing H E OF 26c. I URY M 1 Street, factory, of	PLACE OF DEATH (Chome 5 Residence NJURY AT YORK? YES 2 NO Residence NJURY AT YORK?	PERFOR 1 YES 2 9ck only one) 8 Other (Specify) 26d. DESCRIBE HOW I City or Town, State) to the cause(e) and main time, data and place, and	NJURY OCCURE and Number or R	AAALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY 1 YES 2 NO FINAL ROUTE Number, TO DEATH ROUTE Number, Number Route Number,	
BE COMPLETED BY PHYSICIAN: MEDICAL	that initiated events resulting in death) LAST PART II. Other significant condition O CON O O O O O O O O O O O O O O O O O	d	pertient 3 DOA 28b. TIMI INJ Y — At home, farm, a wiedge, death occurre on and/or investigatio	26. OTHER: 4 Nursing Hi E OF URY M 1 itreet, fectory, of	PLACE OF DEATH (Chome 5 Residence NJURY AT YORK? YES 2 NO lics te and place, and due death occured at the	PERFOR I VES 2 Bock only one) B Other (Specify) 26d. DESCRIBE HOW I City or Town, State) to the cause(s) and maintime, date and place, and IBER	NJURY OCCURE and Number or R where as stated. d due to the car 29d. DATE SIG.	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY 1 YES 2 NO	
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	1 - FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF H		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Lest)		CENTIL	FICALE OF	DEATH	REG. NO		3. TIME OF DEATH	
1 9	Verna	S.	Price			March 16	N 1993	YEAR	
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday,	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign	
	407-80-0228	1 🗆 M 2 🕢 F	85 YRS.	MONTHS DAYS	HOURS MIN.	March 23	1007	Country) Tonnossoo	
	Se. FACILITY NAME (If not institution, give si	reet end number)	0.5	9b. CITY, TOWN	OR LOCATION OF OE			TY OF DEATH	
OR	Annapólis Conval	escent Cent	ter	Anno	apolis		Anna	Arundel	
Б	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			TY, TOWN OR LOCA					
DIRECTOR		Arundel	100.00	Glen Bur			10d. INSIC LIMIT 1 — YES		
FUNERAL	100. STREET AND NUMBER 409 Warlock Cou	nt		10	21061			en of what country? ted States	
NE NE	11. MARITAL STATUS		R IN ILS ARMED	13 WMS OF		IC ORIGIN? (Specify Yes			
	1 Never Merried 2 Merried	12. WAS OECEDENT EVE FORCES? 1 2 YE IF YES, GIVE WAR OF	ES 2 X NO	If yes, sp	ecify Cuben, Mexican 2 XXIO Specify.	n, Puerto Ricen, etc.)	or No	14. RACE — American Indian, Black, White, atc.	
84	Widowed 4 Divorced		0.000	1	Z ZDĄO Opaciny.			spectly: White	
TED	15. DECEDENT'S EOUC (Specify only highest grade	CATION completed)	16a. DECEDENT' (Give kind of	S USUAL OCCUPATION f work done during mo	ON ost of working	16b. KIND OF BU	SINESS/INDU	ISTRY	
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homer			J .	lome.		
OM	17. FATHER'S NAME (First, Middle, Last)		110 men	naice	18. MOTHER'S NAM	AE (First, Middle, Maiden			
BE C	Clyde Smith					Lilly Te	rry		
10	190. INFORMANT'S NAME (Typo/Print) Ralph Price			Warlock		oute Number, City or Tow Glen Burni			
	20e. METHOD OF DISPOSITION	nual from Cinto	20b. PLACE AND DATE	E OF DISPOSITION (Ne	ame of	DATE 20c. LO			
	4 Donation 8 Other (Specify)		Lee Memo	iial Ceme	tery	Wo	odway	Virginia	
	21. SIGNATURE OF FUNERAL SERVICE US	EMSEE ///	10	22. NAME AI	ND ADDRESS OF FAC	John M.	Tayl	or Funeral Home	
	Chalo	1. 6/2	Leen	147 Du	ike of Gli	oucester S	it. An	napolis, MD	
	23. PART I. Enter the diseases, or o	pmplications that say	and the death On						
	shock or beert fellure	let only one cause or	sed the deeth. Do	not anter the mo	de of dying, such	as cardiec or reep	ratory erre	st, Approximate	
	IMMEDIATE CAUSE (Finel	List only one cause or	sed the deeth. Do n each line.	not anter the mo	de of dying, such	as cardiec or reep	ratory erre	Approximate Interval Between Onset and Death	
	snock, or neart isliure.	List only one cause of	n each line.	not anter the mo	de of dying, such	as cardiec or reep	ratory erre	Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	List only one cause of	sed the deeth. Do n each line.	not anter the mo	ode of dying, such	as cardlec or reep	ratory erre	Interval Between	
ION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions,	List only one cause of	s consequence	T Vus	de pf dying, such	MM MM	ratory erre	Interval Between	
CATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING	DUE TO (OR A	s a consequence	T Vus	ode of dying, such	Mas cardiec pr reep	ratory erre	Interval Between	
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1 7 1	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR A	S CONSEQUENCE	OF):	MUIDA	Part I. 24a. WAS AN PERFOR	AUTOPSY MED?	Interval Between	
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I T. I	SHOCK, OF NEST TRIBUTE. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentisity list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 27. MANNER OF DEATH	DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A	S CONSEQUENCE (S A CONSEQUENCE (The but not resulting Dutpettent 3 DOA RY 285. Till 285. Till	OF): OF): OF): OF): OF): OTHER: A Hursing Hom ME OF 26c. INJ	g ceuse given in I	Part I. 24a. WAS AN PERFOR	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
BY PHYSICIAN: MEDICAL	SHOCK, OF NEST TSHURE. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation	DUE TO (OR A DU	CONSEQUENCE (S CONSEQUENCE (A CONSEQUENCE (A Dutpetient 3 DOA RY 28b. Till	OF): 26. PI OTHEM: 4 Filling Hom ME OF MUTHUM WC M 1	g ceuse given in I	Part I. 24a. WAS AN PERFOR 1 YES 2 ck only one) B Other (Specify) 28d. DESCRIBE HOW I	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
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ETED BY PHYSICIAN: MEDICAL	SHOCK, OF NEST TRIBUTE. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentisity list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 MO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSIC	DUE TO (OR A DU	S A CONSEQUENCE (S A CONSEQUENCE (A	OF): OF): 26. PI OTHEM: 4 Mursing Horr ME OF MURY MILE Street, factory, office rived et the time, date	g ceuse given in I	Part I. 24a. WAS AN PERFOR 1 YES 2 Ck only one) B Other (Specify) 284. LOCATION (Street City or Town, Stele) to the ceuse(e) end mer	AUTOPSY MED? NO NJURY OCCU	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
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BE COMPLETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	DUE TO OR A DUE T	S A CONSEQUENCE (S A CONSEQUENCE (A	OF): OF): 26. PI OTHEM: 4 Mursing Horr ME OF MURY MILE Street, factory, office rived et the time, date	g ceuse given in I LACE OF DEATH (Che te 5 Residence 1 IURY AT JOHK? YES 2 NO e end plece, end due	Part I. 24a. WAS AN PERFOR 1 YES 2 2 2 2 2 2 2 2 2 2	AUTOPSY IMEO? 3-No NJURY OCCU and Number of the did due to the 29d. DATE	Interval Between Onset and Death Onset and Death 24b. Were autopsy Findings AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO JRED Were Autopsy Findings AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO JRED Were Autopsy Findings AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO JRED Were Autopsy Findings AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 Couse(a) end menner ee stated.	
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BE COMPLETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation Investigation 2 Accident 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	DUE TO (OR A DU	S CONSEQUENCE (S A CONSEQUENCE (A CONSEQUENCE (A Dutpettent 3 DOA ATY 28b. Till B DIATH ITEM 17 (Type Towledge, death occur withon end/or investiget	OF): OF):	g ceuse given in I LACE OF DEATH (Che te 5 Geldence in 1984) VYES 2 NO e end plece, end due teath occured at the 19 29c. LICENSE NUM D3118	Part I. 24a. WAS AN PERFOR 1 YES 2 2 2 2 2 2 2 2 2 2	AUTOPSY MED? AND NURY OCCU and Number of the did due to the 29d. DATE	Interval Between Onset and Death Onset and Death 24b. Were autopsy Findings AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO JRED Were Rural Route Number, d. ceuse(a) and menner ee stated. SIGNED (Month, Day, Year) Arch 17, 1993	

and the second second

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	REGISTRAN		CENTIF	ICATE	DEATH	REG. NO	D					
- 3	1. DECEDENT'S NAME (First, Middle, Last)	771	-	T TDG		2. DATE OF DEATH MONTH	DAY 1.0.0	YEAR 3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER	Albert		LIPS		March 11	, 199.					
	214- 42- 1448	1 × M 2 F	(In yrs. last birthday) 49 YRS.	IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) Oct. 10,	1943	8. BIRTHPLACE (State or Foreign Country) Yarrowsburg, Md.				
_	9a. FACILITY NAME (If not institution, give a	street and number)			OR LOCATION OF E	HTAS	1111	NTY OF DEATH				
DIRECTOR	2246 Kaetzel	Rd.		Knox	ville		Wasl	hington				
띪	10a. STATE 10b. COUNT	Y	10c. CIT	Y, TOWN OR LOC	10d. INSIDE CITY							
		shington	K	noxvill	е			1 YES 2 NO				
FUNERAL	10s. STREET AND NUMBER			IOF. ZIP CODE			ZEN OF WHAT COUNTRY?					
빌	2246 Kaetzel Ro	12. WAS DECEDENT EVER	MILLO ADMICO	1 40 440 0	21758			S. A.				
디디	1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes,	pecify Cuban, Mexic	UNIC ORIGIN? (Specify Year, Puerto Rican, etc.)	es or No	14. RACE — American Indian, Black, White, etc.				
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 U Y	S 2 PNO Spec	ffy:		Specify: White				
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S	USUAL OCCUPA	TION post of working	16b. KIND OF B	JSINESS/IND	USTRY				
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	Me. Do NOT us	eo retired.)		Davel	·					
₩.	12		Branch	Bank Ma		Bank						
8	17. FATHER'S NAME (First, Middle, Last) George Albert Ph	villine				AME (First, Middle, Maide zabeth Vir		Kelhaugh				
BE	19a. INFORMANT'S NAME (Type/Print)	iiiips	195 MAILING	ADDRESS (Stone		Route Number, City or To	_	-				
유	Sharon L. Phill	.ips				Knoxville						
	20a. METHOD OF DISPOSITION 1) Burlal 2 Cremation 3 Rem	oval from State	Ob. PLACE AND DATE ometery, crematory or o	ther place)				City or Town, State				
	4 Donation 5 Other (Specify) Brownsville Hats Cemetery 3-13-93 Brownsville, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	John Il Mande	John H. Ba	st, Jr.	BAST	FUNERAL	TIL MALE.		National Pike				
	23. PART I. Enter the diseases, or shock, or heart fellure.	complications that cause	ed the death. Do	not enter the n	ode of dying, su	ch as cardiec or ree	oiratory am	est, Approximate				
	IMMEDIATE CAUSE (Finel							Interval Between Onset and Death				
	disease or condition resulting in death) ###################################											
	DUE TO (OR AS A CONSEDUENCE DF):											
No.	Sequentially list conditions, OUE TO (OR AS A CONSEDUENCE DF):											
AT	if any, leading to immediate cause. Enter UNDERLYING	-	N CONSEDUENCE D	.).								
CERTIFICATION	CAUSE (Disease or Injury that initiated events	C. DUE TO (DR AS	A CONSEDUENCE O	F):								
FR	resulting in death) LAST	d										
	PART II. Other significent condition	as contributing to deeth	but not resulting	In the underly	na ceuee alven le	Part I. 24s. WAS A	N ALITOREY	24b. WERE AUTOPSY FINDINGS				
EDICAL			not recenting	in the underly	ing course given in	PERFO	RMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE				
						1 TES	2 NO	OF DEATH?				
Σ.			<u> </u>					1 TES 2 YEANO				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			26.	PLACE OF DEATH (C	heck only one)						
Sic	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Ou	tpatient 3 DOA	OTHER:	,	6 ☐ Other (Specify)						
Ť	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)		E OF 28c. II	JURY AT	28d. DESCRIBE HOW	INJURY OCC	CURED				
ВУ	1/ Natural 5 Pending Investigation	(month, buy, rour)			YES 2 NO							
	3 Suicide 6 Could not be 4 Homicide detarmined	28a. PLACE OF INJUF building, etc. (Sp	ty — At home, larm, : ecify)	street, factory, of	Ice	28f. LOCATION (Street City or Town, State	and Number	or Rural Route Number,				
91	29a. CERTIFIER	CAN TO DE LOCALISTA		72.2 Nr								
COMPLETED		CIAN: To the best of my kno						e Cause(a) and manner as stated.				
BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	Brono	M DEms	12 ms	29c. LICENSE NU	IMBER /	29d. DATE	E SIGNED (Mgnth, Day, Year)				
ē.	30. NAME AND ADDRESS OF PERSON WH	O COMPLETES SAMES SE		/	3/			11-73				
	BRIAN M. O CONN	COMPLETED CAUSE DF 0	CATH (ITEM 27) (Type	Print)	FRE	DERICK	MA	21701				
296. SIGNATURE AND TITLE OF CERTIFIER 296. SIGNATURE AND TITLE OF CERTIFIER 296. DATE SIGNED (Mogniti, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE DF DEATH (ITEM 27) (Type, Print) BRITAN M. O'CONNOR, MA 501 SEVENTH ST., FREAERICK, MA 2170/ 31. DATE FILED (Moniti, Day, Year) 32. REGISTRAR'S SIGNATURE MAR 12 1993 432. REGISTRAR'S SIGNATURE												

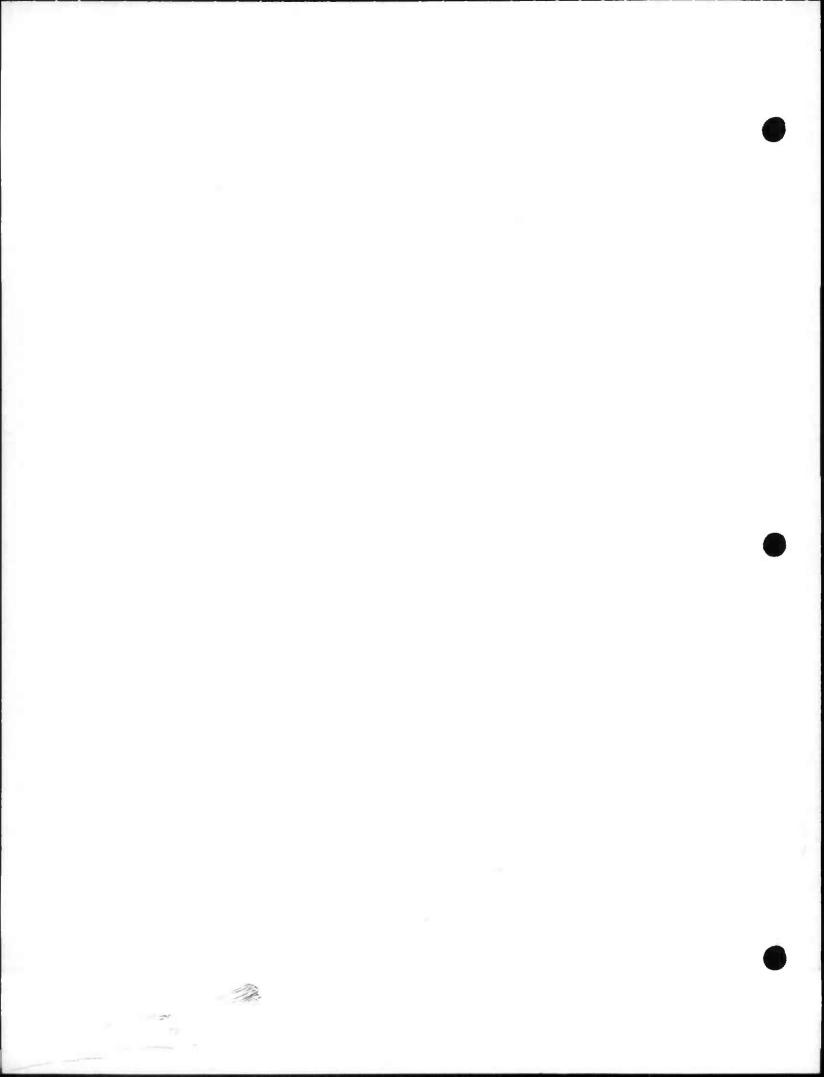
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOS TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

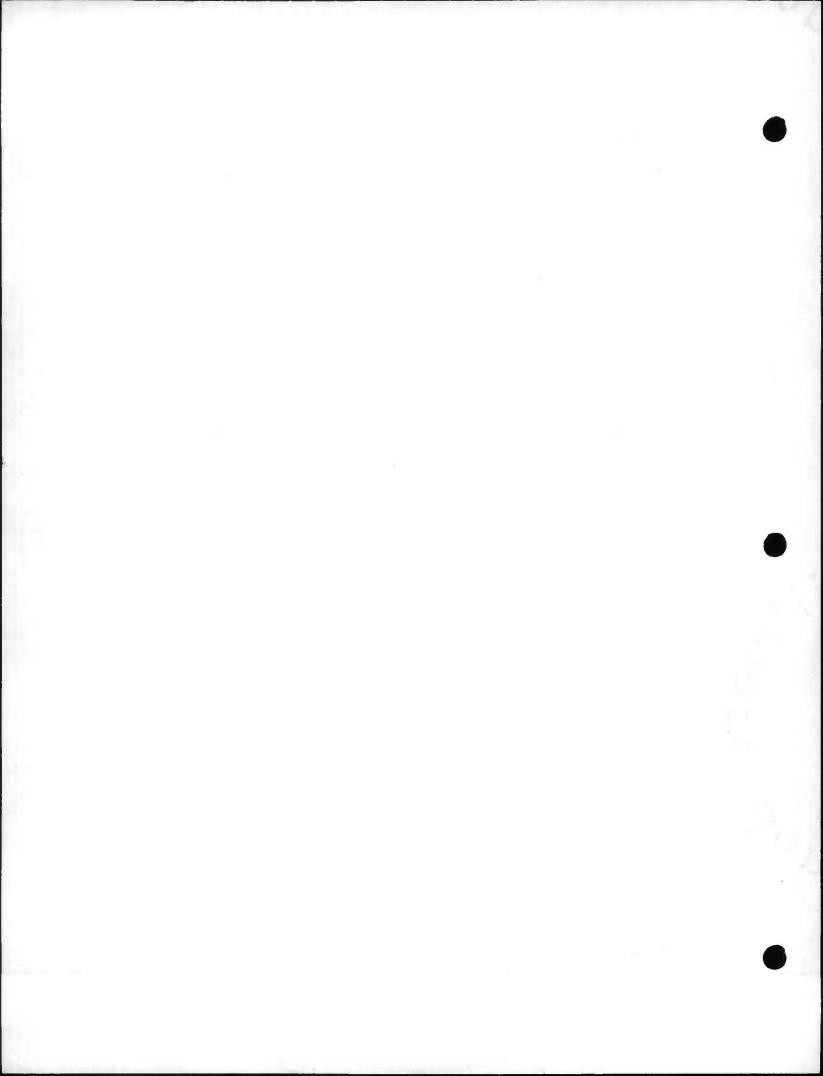
TO THE PASPIAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the look physician. TOTHE FULERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. To hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

							(93 08908			
	REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL HYGIE REG. N					
	1. DECEDENT'S NAME (First, Middle, Last) Harry E. Po	rtner, Sr.				2. DATE OF DEATH MONTH	DAY 13	year 2:20 A. M			
7	4. SOCIAL SECURITY NUMBER 5. 215-18-2604	SEX 6. AGE (In	yrs. last birthday) 8 1 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct. 15,		BIRTHPLACE (State or Foreign Country) Waryland			
ron	Des. FACILITY NAME (If not institution, give street Washington County	· ·			gerstown	EATH	9c. COUNT	y of DEATH hington			
DIRECTOR	10a. STATE 10b. COUNTY Md. Was			10d. INSIDE CITY LIMITS? 1 YES 2 NO							
FUNERAL	100. STREET AND NUMBER 23946 FOXVILLE Rd.			Smiths 10	21783			N OF WHAT COUNTRY?			
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, sp		NIC ORIGIN? (Specify Yen, Puerto Ricen, etc.)	es or No— 1	4. RACE — American Indian, Black, White, etc. Specify: White			
COMPLETED	15. DECEDENT'S EDUCAT (Specily only highest grade con Elementary/Secondary (0-12)	ION npleted) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of w life. Do NOT us	USUAL OCCUPATION or done during more retired.)	st of working	16b. KIND OF B	usiness/inous	STRY			
BE COM	17. FATHER'S NAME (First, Middle, Last) John M. Portner					ME (First, Middle, Meide CeliaAnn	Comfor				
5	190. INFORMANT'S NAME (Typo/Print) Peggy J. Portner					House Number City or R IWN, Md. 21		ode)			
1	20e. METHOD OF DISPOSITION 1 (X) Burial 2 Cremation 3 Remova 4 Donation 5 Other (Specify)	I from State 20b. P	ery, cremetory of or	PEDISPOSITION (Ne	metery 3	DATE 20c. 1 3-18-93 S	ocation – ch mithsbi	ty or Town, State Wrg, Md.			
	21. SIGNATURE OF FUNERAL SERVICE LICENS	The world	5	22. NAME AL	ID ADDRESS OF FA	CILITY		wrg, Md. 21783			
	23. PART i. Enter the diseases, or com shock, or heert fellure. Lis	pilications that caused to any one cause on each	the death. Do n	ot enter the mo	de of dying, suc	h as cardiac or ree	piratory arres	at, Approximate interval Between			
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	Myoca	4 m/	In	farc	tion		Onset and Daath			
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSEQUENCE OF): COTONARY ACTION DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury) CAUSE (Disease or injury)									
CERT	resulting in death) LAST										
MEDICAL	PART II. Other eignificant conditions o	ontributing to death but	not resulting in	n the underlying	g cause given in		N AUTOPSY DRMED? 2 A NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	CORPITAL			ACE OF DEATH (C)	eck only one)					
HYSI	~ /	OSPITAL: Inpatient 2 ER/Outpate 28e. DATE OF INJURY	lent 3 DOA			8 Other (Specify) 28d. DESCRIBE HOW	IN HIRV OCCU	Den.			
ВУ Р	Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	ILMI	M 1 .	RK? /ES 2 NO						
ETED	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify	- AL NOME, TAM, 8	uwet, ractory, offic	•	281. LOCATION (Stree City or Town, Stee	t and Number or B)	Hurel Route Number,			
OMPLET		N: To the best of my knowled on the basis of sxamination a						cause(s) and manner as stated.			
BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER	3km			29c. LICENSE NU			BIGNED (Month, Day, Year)			
유	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEAT	H (ITEM 27) (Type,	Print)		1//	1	11/1/3			

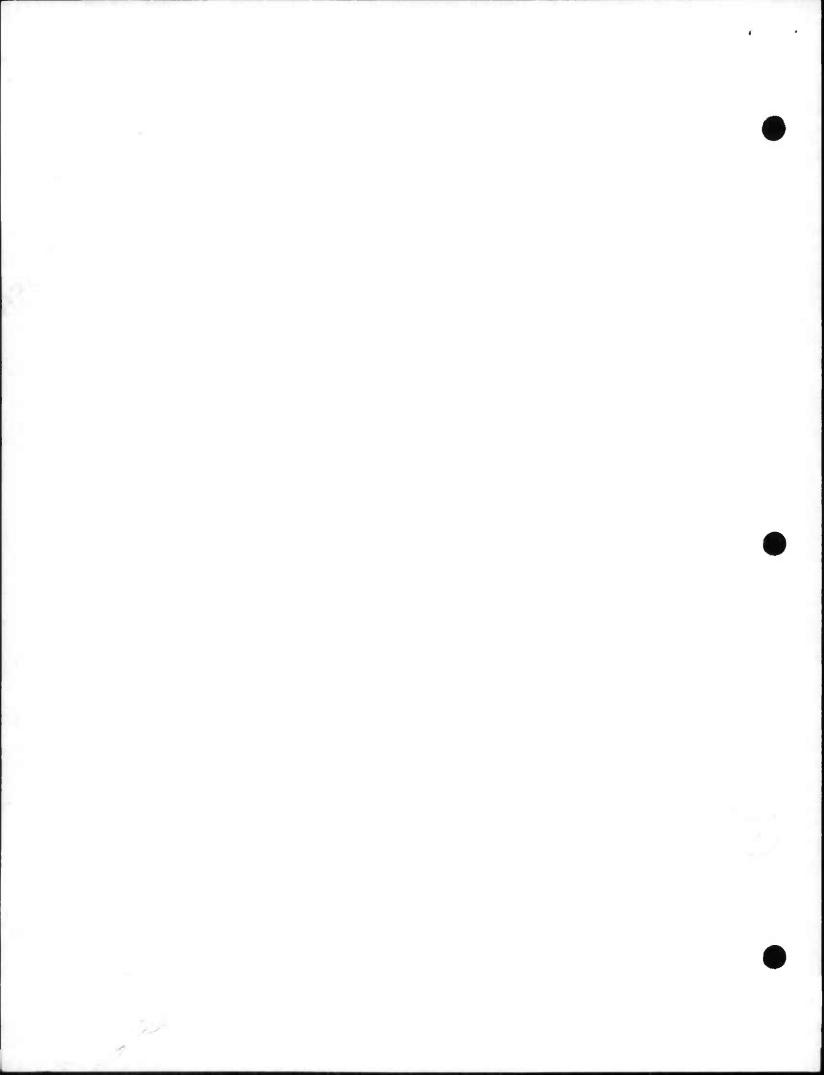
William B. Kerns M.D. 22911 Jefferson Blvd Smithsburg, Md. 21783

31. DATE FILED (Mornin, Day, 1967)
MAR 1 1993

32. REGISTRAR'S SIGNATURE



		1 - STATE REGISTRAR	TE OF MARYLAND / CE		TOF HEALTH A E OF DEATH			
	1	1. DECEDENT'S NAME (First, Middle, Last)	A .			2. DATE OF DEATH		3. TIME OF DEATH
		DOROTHY G	. PAY	ne_		MONTH 3	18 9	3 11.15A.M
		4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs.' Ina	t birthday) IF UNDER YRS. MONTHS		MIN. (Month, Day, Year)	(BIRTHPLACE (State or Foreign Country)
should	3	9a. FACILITY NAME (If not institution, give street and	12		TOWN OR LOCATION	9/12/20 OF DEATH	9c, COUNTY	ennsylvania
ري دي ه	OR		ORIAL HOS	pital /	LAUREA	le GRACE	Harf	ord
	DIRECTO	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, TOWN C	OR LOCATION	77.17		10d. INSIDE CITY
permit. Pages	DIR	Maryland Harf	ord	Aberd				LIMITS?
	3AL	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
020 physician. burial-transit	FUNERAL	1 West Inca Street 11. MARITAL STATUS 12. WAS			21001			S.A.
020 physician. burial-trar		1 Never Married 2 Married FOF	OECEDENT EVER IN U.S. ARI ICES? 1 YES 2 N ES, GIVE WAR OR DATES	ю	If yes, specify Cuben,	HISPANIC ORIGIN? (Specify Mexican, Puerto Rican, etc.)		RACE — American Indian, Black, White, etc.
oding sthe	D BY	3 Widowed 4 Divorced	Ed, Care Wall On Bales		1 - YES 2 17 NO	зресну:		specify: hite
121 r afte	ETE	15. DECEDENT'S EDUCATION (Specify only highest grade complete	(G/	CEDENT'S USUAL OF ve kind of work done of Do NOT use retired.)	CCUPATION during most of working	16b. KIND OF E	USINESS/INDUST	RY
M = 5	PLE	Elementary/Secondary (0-12) College	(1-4 or 5+)	vil Serv	ice	II S	Governm	ent
by the hospital of the detached for at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		VII GCIV.		R'S NAME (First, Middle, Maid		aic
RYL ed by uld be	BE	Gordon S. Graham				a G. Foster		
MARYLAND s retained by the hospit S should be detached notified at once.	2	Mr. Clifford D. Jone			S (Street and Number or Even Apts	Plural Route Number, City or To		
	4	20a. METHOD OF DISPOSITION	20b. PLACE A	ND DATE OF DISPOS	ITION (Name of	DATE 20c.	OCATION - City	or Town State
BALTIMORE, er death. Page 6 may bu the funeral director, page val.	1	MXBurial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State cometery, cree Ayers	chape I	Methodist	Cem, 3/20 Wh	ite Hal	l, MD
ALTIN death. Pag e funeral dia J. examiner		21. SIGN TURE OF FUNERAL SERVICE LICENSEE		22.	NAME AND ADDRESS			
. 0 = 0		Hary K. With	uvanni	<i>E</i>	Aberdeen,	Maryland 2	1001–339	99
		23. PART I. Enter the diseases, or compiler shock, or heart failure. List only	tions that caused the de one cause on each line.	ath. Do not enter	the mode of dying	, such as cardiac or res	piratory arrest,	Approximate interval Between
24 mg mg 24	1	IMMEDIATE CAUSE (Final disease or condition	7. Ha Po	··· 0 +	2. 1			Onset and Death
1760, ted within 24 completely fille ial, cremation, event, the		resulting in death)	DUE TO (OR AS A CONSEC	DUENCE OF):	agree			
68760, executed with and complete burial, crem matic event	N	Sequentially list conditions,	CHF.					
Clan clan to to to to	ATI	if any, leading to immediate cause. Enter UNDERLYING	DUE TO JOIN AS A CONSEC	PUENCE OF):		0		!
Physical D	J.F.	CAUSE (Disease or injury fat initiated events	DUE TO JOH AS A COMBED	WENCE OF):	0 /	7 //)	
D 5 5 5	CERTIFICATION	resulting in death) LAST	Bleedu	of au	odluak	weer		
E Me d	CAL C	PART II. Other significant conditions contri	buting to death but not n	earlting in the un	derlying cause giv		UN AUTOPSY	24b. WERE AUTOPSY FINDINGS
ORE s that the ned by lith and any in						PERF	2 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
M requires that the stand pt. of Health and Shows and	MED							1 YES 2 NO
23 t as t	AN	25. WAS CASE REFERRED TO MEDICAL			20 21 405 05 25 25			
N: Th N: Th State State	PHYSICIAN:	EXAMINER? HOSE	TAL: atlent 2 ER/Outpatient 3	DOA 4 Num		lence 6 Other (Specify)		
. 5 5 5	¥	T	. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCURE	:D
ON OF ping PHYSi frer this c death with marked,	B	1 Natural 5 Pending 2 Accident Investigation		:M:	t YES 2 P	//		
-		3 Suicide 6 Could not be datermined	 PLACE OF INJURY — At hor building, etc. (Specify) 	me, farm, street, fact	ory, office	28f. LOCATION (Stree City or Town, Star		ural Route Number,
	PLET	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To	the best of my knowledge, dea	ath occurred at the ti	ime data and place as	of the to the course(s) and to	anner en eleted	
E 2 2	COME	(Check only one) 2 MEDICAL EXAMINER: On the						use(a) and manner as stated,
TO THE HOSE TO THE FUNE TO SHE WITHIN	ш	29b. SIGNATURE AND TITLE OF CERTIFIER	16 1	n	29c, LICENS	SE NUMBER	29d. DATE SK	SNED (Month Day, Year)
E E S M	9 0	1 diau	yes u	D	DI	5/52	> 3	118193
		30. NAME AND ADDRESS OF PERSON WHO COMPL	FYED CAUSE OF DEATH (ITEM	1 27) (Type, Print)				
_		31. DATE FILEO (Month, Day, Year) 32	REGISTRAR'S SIGNATURE		<u> </u>			
		MAR 1 9 '93 &	chia Davidson-Rom	delle				2



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	Pages		
the hospital or attending physician.	IN THE FUNE TO THE CHARACTURE ATTRETOR AND THE ATTRACTOR OF THE ATTRACTOR PHYSICIAN AND COMPLETED BY THE FUNE THE CHARACTOR PAGE 5 should be detached for use as the buriat-transit permit.		onea
The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the	ge 5 should be		e notified at
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I ME	DATE	t filed w	MPORT

93 08910 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Francis __6ctave Panneton 03 93 :50 B.ii. 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F 78 DAYS 578-22-4113A YRS. 09-14-14 N.H. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN DR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Deers Head Center Salisbury Wicomico 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Mo. Worcester Ocean City 1 X YES 2 NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 11000 Coastal Hgwy. #603 21842 USA 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES TATLAT 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 NO Specify: BY WW II Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) Salesman Real Estate 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ovila H. Panneton Clara Ross BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 9 Esther J. Panneton 11000 Coastal Hgwy. #603 Ocean City, M d. 21842 20a. METHOD OF DISPOSITION

1 Burlal 2 Cremation 3 Re
4 Denation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State meters cremetory of other place. Salisbury Crematory Salisbury, Md. 21. SIGNATURE OF FUNERAL SERVICE LICE 22. NAME AND ADDRESS OF FACILITY Ullrich Funeral Home Berlin, Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. nterval Betwe IMMEDIATE CAUSE (Final Onset and Death disease or condition Cancer of the prostate with metastasis to the bond resulting in death) DUE TO (OR AS A CONSEQUENCE OF): PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO 1 TES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 TYES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending Investigation 1 YES 2 NO BY 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) COMPLETED 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicida 29s. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or in stigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Bay, Year) Bento 5 3 92 20050 13 han 2

547-D Riverside DR. Salisbury, MD 21801

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNALUNE

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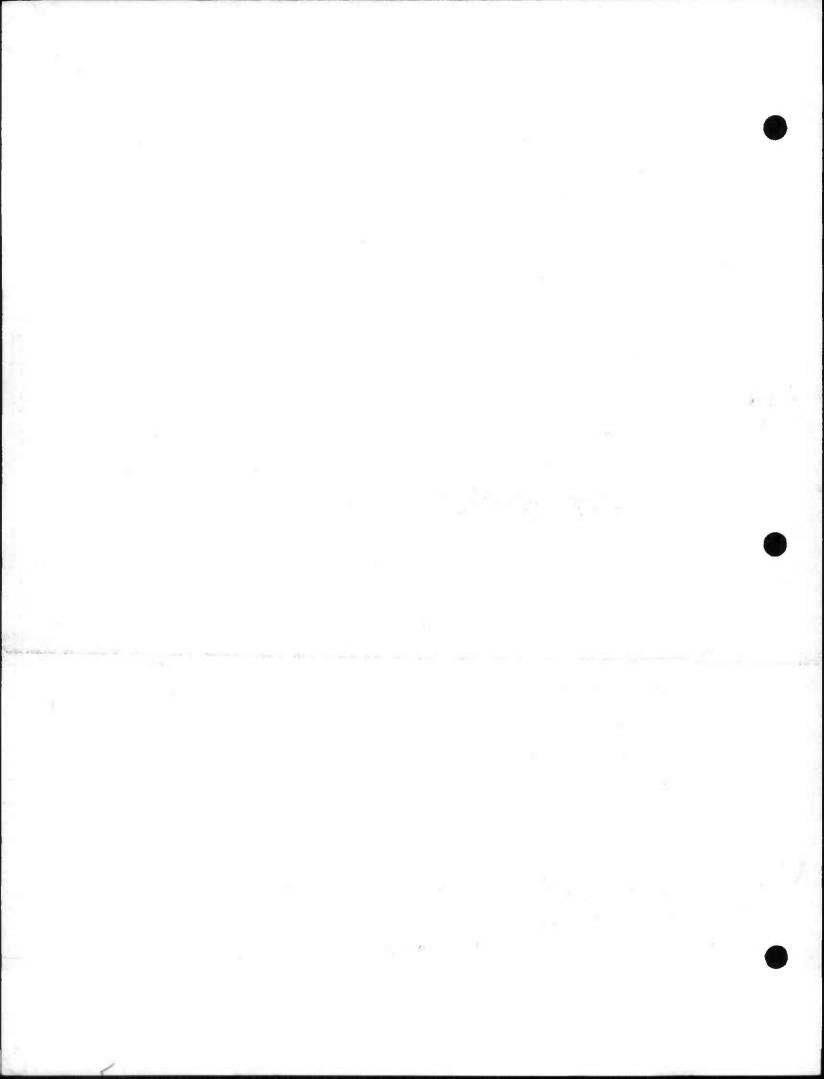
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31. DATE FILED (Month, Day, Year)
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BALTIMORE, MARYLAND 21215-0020	er death. Page 6 may be retained by the hospital of analytics and the property of analytics and the second of the	the funeral director, page 5 should be detached forguse as no personne	odi.	The second of th
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OH ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital of annual	THE CIDE After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as in	The second with the plate begin, or regard and mental inviting the profit of combast, or removal, the marked or item 23 shows any injury or other traumatic event the madical examinar must be notified at once.	
	TO THUSPIT	TO THE FOREIGN	MPORTANT	

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPA CERTII	RTMENT OF I	HEALTH AND	MENTA	L HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last) CELIA G.	PLOTKIN				2. DATE	OF DEATH	AY A	KEAR 3.	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	In yrs. lest birthday		IF UNDER 24 HRS.	7. DATE	OF BIRTH		BIRTHPL	ACE (State or Foreign
pin		278-50-0319 9a. FACILITY NAME (If not institution, give s	**	90 YRS.	MONTHS DAYS	HOURS MIN.	July	25,		Russ.	
2, 3 should	стов	Suburban Hospita			Rockvi.	OR LOCATION OF D	EATH		9c. COUNT	Y OF DEAT	
₩.	ECT	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	ν	100 0	ITY, TOWN OR LOCA	71011					
it. Pages	DIR	Virginia Fair	1		Vienna	TION					Id. INSIDE CITY LIMITS? YES 2 NO
	ERAL	100. STREET AND NUMBER 2431 Villanova Dr	ri ve		10	1. ZIP CODE 22180					T COUNTRY?
. P	S. S.	11. MARITAL STATUS	12. WAS DECEDENT EVER II	V U.S. ARMED	13. WAS DEC	CENDENT OF HISPA	NIC ORIGIN	17 (Specify Yes	U.S	I. RACE -	American Indian,
-0050	BX	1 Never Married 2 Married WWW Wildowed 4 Divorced	FORCES? 1 TYES	2 X NO ATES		ecity Cuban, Maxic 2 NO Speci		Rican, atc.)		Black, W	White
21	ETER	15. DECEDENT'S EDU (Specify only highest grade	completed)	16a. DECEDENT' (Give kind on life. Do NOT	S USUAL OCCUPATION work done during me	ON ost of working	16b	. KIND OF BU	SINESS/INDUS	TRY	
AD 2 hospital ched for			College (1-4 or 5+) OT AVAILABLE	Homem	,			Own	Home		
, MARYLAND 212 be retained by the hospital of at 18 5 should be detached fortuse 3 notifiled at once.	E COMP	17. FATHER'S NAME (First, Middle, Last) UNKNOWN	Goldberg			16. MOTHER'S NA Masha	AME (First,)	Middle, Malden	Surname) UNKNO	T.71\7	
MAR retained 5 should notified	0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS (Street a		Route Numi	ber, City or Tow			
ay be ret page 5 s	10	Marchia L. Solmse	en	526 V	idal Dr.,	San Fra	ncisc	o, Cal	liforn	ia 🤄	94132
IMORE Page 6 may Il director, pa		20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Rem XX Donation 5 Other (Specify)	ovel from State cam	etery cramatory or	other place)		OAT		CATION — CIT		
ALTIMOF leath. Page 6 m funeral director, xaminer must		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSUS /	U Wasii (Univ Med	NO ADDRESS OF FA	CILITY				D.C.
0 = 0		* Aff	/achu	<u>.</u>	9013 Z	on/Hale I Annapolis	Rd.	,Lanha	am, Mar	yland	20706
24 ji ji ji ji ji ji ji ji ji ji ji ji ji		IMMEDIATE CAUSE (Final	List only one couse on e	ech line.	not enter the mo	de of dying, suc	ch as card	flec or respi	ratory arres	t,	Approximata interval Between Onset and Death
withir npletel crema		resulting in death)	DUE TO (OR AS A	CONSEQUENCE		1					5 days
Y	NOI	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE	in puln	iony di	iear	4			Yews
BO) cate be thysician pr prior	ICAT	cause. Enter UNDERLYING CAUSE (Disease or injury	c. Kyphosco								Years
S, P.O. Bodeath certificate attending physiental Hygiene print, or other to	CERTIFICATION	that initieted events resulting in death) LAST	d	CONSEQUENCE	OF):						
9 4 3 1	AL C	PART II. Other algnificant condition	a contributing to deeth b	ut not reaulting	in the underlying	g ceuse given in	Pert I.	24a. WAS AN		24b. WE	RE AUTOPSY FINDINGS
H that the that a man a	MEDIC	Corony heart	disan				_	PERFOR		00	MILABLE PRIOR TO MPLETION OF CAUSE DEATH?
redui	ME	Ponluisons du	score				_				YES 2 NO
23 b b b b b b b b b b b b b b b b b b b	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	in gas Treston	7	26. PI	ACE OF DEATH (Ch	eck only on	e)			
VIIAN: The rufficate he State or item	Sic	EXAMINER?	HOSPITAL:	atient 3 DOA	OTHER:	e 5 🗆 Residence					
NG PHYSIC fer this cer sath with th	ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. Til	IJURY WO	URY AT PRK? YES 2 NO	28d. DES	CRIBE HOW I	NJURY OCCUP	IED	
TENDI TENDI	ETED B	2 Accident Investigation 3 Suicide 6 Could not be determined	28s. PLACE OF INJURY building, stc. (Spec	— At home, farm,	atreet, factory, offic	•		ATION (Street a or Town, State)	and Number or	Rural Route	Number,
DESPITA DR. METAL DIRECTOR AND THE MAN TO TH	COMPLI		CIAN: To the best of my knowl R: On the basis of examination								d manner as stated.
TO THE PORTER. TO THE PORTER. IMPORTANT:	H	296. SIGNATURE AND TITLE OF CERTIFIER		.8		29c. LICENSE NUI	MBER 1 / 97)	29d. DATE S	IGNED (MO	orith, Day, Year)
- 2-W-4	٩	SE NAME AND ADDRESS OF PERSON WH	hen MD		e. Primi zrestitu	1 /4.	R. I	. 11	4.0	7 (0).0	-7
		31. DATE FILED (Month, Day, Year)	32. REGISTRAPIO SIGNA	ATURE	10	, and	10004	UILL	NU	-011	-



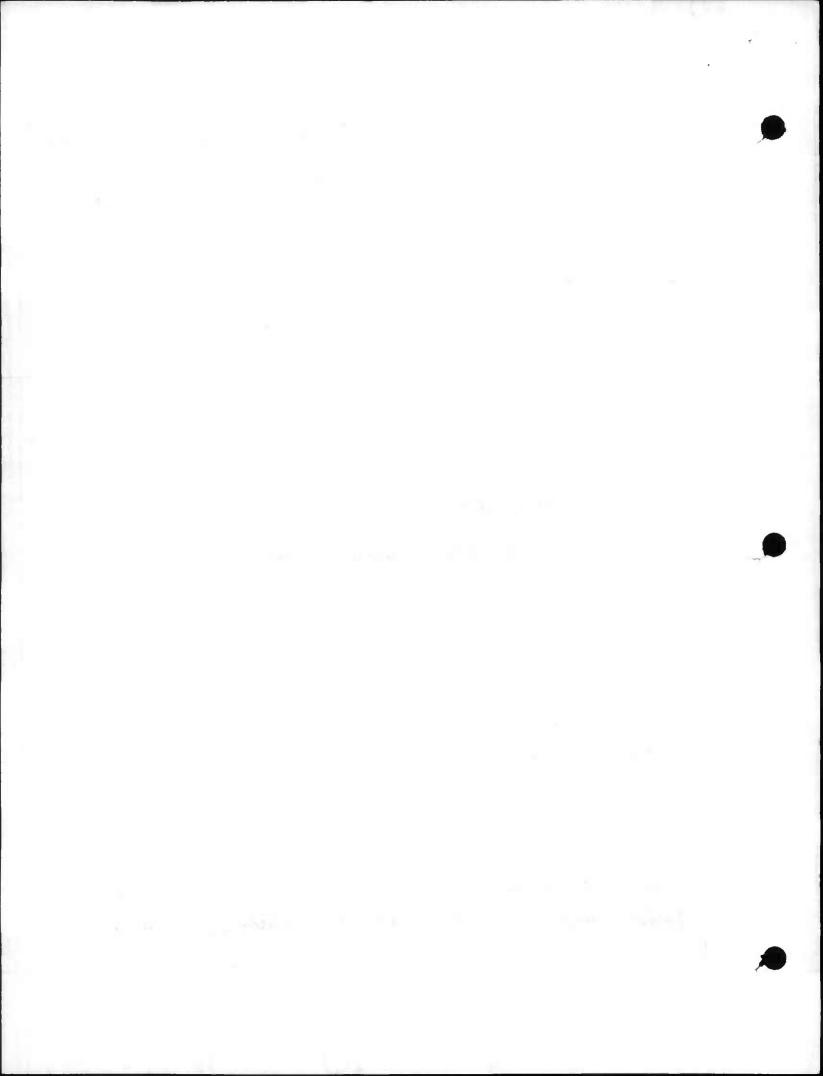
FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR				CERTII	ICATE (OF DEATH	J. W.E.	REG. NO			
		1. DECEDENT'S NAME (First,	Middle, Last)				\wedge			E OF DEATH		3	. TIME OF DEATH
		Geraldi	ine	F.			P	usey	MOR	- 10 ·		EAR	12:55 PM
		4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (I	In yrs. last birthday,		-		E OF BIRTH		BIRTHPL	ACE (State or Foreign
		213/24/1997		1 [M 2]X] F		64 YRS.	MONTHS DA	YS HOURS MH		11th, Day, Year)		Country)	
pino	1 3	9a. FACILITY NAME (If not in	stitution, give str	reet and number)		0-1	9b. CITY. TO	WN OR LOCATION O		2/1920	9c. COUNTY	aryl	
, 2, 3 should	DIRECTOR	PENINSULA R	EGIONA		L CE	NTER		LISBURY				OMIC	
les 1,	E C	10a. STATE	10b. COUNTY			10c. C	TY, TOWN OR L	OCATION				10	Dd. INSIDE CITY
g.	HO	Maryland	Worces	ster			Pocomok	ce City				1.5	LIMITS?
armit.		10e. STREET AND NUMBER					OCOMO	101. ZIP CODE			10a CITIZEI		AT COUNTRY?
physician. burial-transit permit. Pages	FUNERAL	5143 Flemino	Mill					21851			U	SA	
	ВУ	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES	2 12 NO	If yes	DECENDENT OF HIS s, specify Cuban, Me YES 2 NO Sc	xican, Puert	iiN? (Specify Ye o Rican, etc.)	s or No 14	Black, V Specify:	- American Indian, Vhite, atc. White
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for us	<u> </u>	Elementary/Secondary (0		College (1-4 or 5 -)	life. Do NOT	work done durin ise retired.)	g most of working					
hospital ached fo	린	11				Homema]	cer						
the hospital or attended for use once.	COMPLETED	17. FATHER'S NAME (First, Mi	iddle, Last)					18. MOTHER'S	NAME (First	, Middle, Maiden	Surname)		
2 2 %	BE	Elliott Gr	riffin					Ruth	Drvde	n			
s retained to 5 should notified		19a, INFORMANT'S NAME (7)				19b, MAILIN	G ADDRESS (Str	reet and Number or Ru			m, State, Zip Co	ide)	
5 sl	2	Orville M.	Pusev					g Mill R					1851
page	1	20a. METHOD OF DISPOSITI	ON		20b.	PLACE AND DATE					CATION - CIT		
ector, pag must b		1 St Burial 2 Crematio 4 Donation 5 Other		val from State	came	etery, crematory or	other plece)	it (it to me or	1				
		21. SIGNATURE OF FUNERAL		ENSEE	Rei	nson Cer		RE AND ADDRESS OF	5/	14 Poc	omoke	City	, Ma.
death. Pag e funeral di. J.				000 00				lson Fun		HOme			
		Scory	5./	Melsi	1		PC	BOX 64,	Poco	moke C	ity, M	d.	21851
nours after d in by the or removal		23. PART i. Enter the di	seases, or co	omplications the	t caused	the death. Do	not enter the	mode of dying,	such as ca	rdiec or reap	iratory arrea	t,	Approximata
		IMMEDIATE CAUSE (Fin		Market Committee			,						Onset and Death
		disease or condition resulting in death)	+ ,	Metas	toti	2 Or	61101	n Ce	ne				
		The state of the s		DUE TO	(OR AS A	CONSEQUENCE	OF):						
ysician and con prior to burial, traumatic er	Z	O	b										
e be execute sician and conion to burial traumatic	CERTIFICATION	Sequentially list conditi if any, leading to immed	liate	DUE TO	(OR AS A	CONSEQUENCE	OF):						
eath certificate be a attending physician mai Hygiene prior to y, or other traur	₫	CAUSE (Disease or inju		·									
h certificate anding physi Hygiene pr or other to	1	that initiated events resulting in death) LAS		DUE TO	(DR AS A	CONSEQUENCE	OF):						
tendii al Hy	H	resulting in death) LAS	d										
he death certifica the attending ph Mental Hygiene njury, or other		PART II. Other aignifica	nt conditions	contributing to	death hi	tt not requiting	in the under	hulaa aayaa ah	In Part I	T una	ALPRODAY		
and by	DICAL			contributing to	Caatii De	at not readiting	in the didei	lying cause given	in Parti.	24a. WAS AN PERFOR		AM	ERE AUTOPSY FINDINGS MALABLE PRIOR TO
	ă									1 🗆 YES 2	NO DI		OMPLETION OF CAUSE F DEATH?
requires been signe of Healt	ME											1 !	YES 2 NO
law las bept.	Ž.									<u> </u>			
IE HOSPITAL OR ATTENDING PHYSICIAN: The law requires IE FUNERAL DIRECTOR: After this certificate has been sign of within 72 hours after death with the State Dept. of Hea OFTANT: It Item 28 is marked, or Item 23 shows	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HQSPITAL:			OTHER:	6. PLACE OF DEATH	(Check only	one)			
CIAN:	YS	1 D YES 2 NO				atlent 3 DOA		Home 5 - Residen	ce 6 🗆 Oti	ner (Specify)			
HYSII his ce with t	РНУ	27. MANNER OF DEATH	Pending	28a. DATE OF (Month, D	INJURY sy, Year)	28b, TI	JURY 28c	. INJURY AT WORK?	28d. D	ESCRIBE HOW I	NJURY OCCUP	IED	
NDING PHYS I: After this or r death with is marked,	B		nvestigation					YES 2 ND					
R: Ail	ED		Could not be	28e. PLACE O building,	F INJURY - etc. (Speci	- At home, ferm,	atreet, factory,	offica	281. LC	CATION (Street by or Town, State)	and Number or	Rural Rout	e Number,
ATTE ECTO In 28	ETE	4 Homicide	letermined										
L OR / DIRECT Hours	P	29a. CERTIFIER (Check only	IFYING PHYSIC	IAN: To the best of	my knowle	edge, death sicus	red at the time,	date and place, and	due to the c	ause(a) and mai	nner as stated.		
HOSPITAL FUNERAL WITHIN 72 I	COMPL											euse(s) ar	nd manner as stated.
FUN With		29b. SIGNATURE AND TITLE	OF CENTIFIER	-11	1	4/11	_	29c, LICENSE	NUMBER		294 DATE S	IGNED /M	onth, Day, Year)
一	BE	AL 7	/ /	1	1	1 W	3	026	27	8	▶ .3.	- 10-	-93
2 2 ₹	0	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEA	TH (ITEM 27) (See	e. Print)	1000	-1	0		/	1
المدا		Dovid Co	reall,	NO /	45 E		611 51	5.	lich	8 , W	1 210	(6)	
		31. DATE FILED (Month, Day, 1		32/REGISTRA			- // 0/	1 000	113/	1 WI	N III	, -/	
	15	MAR 15	1993	Frie 5	- معانی	Russe			(
		O T MAIN	1000	3	0	. /							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,



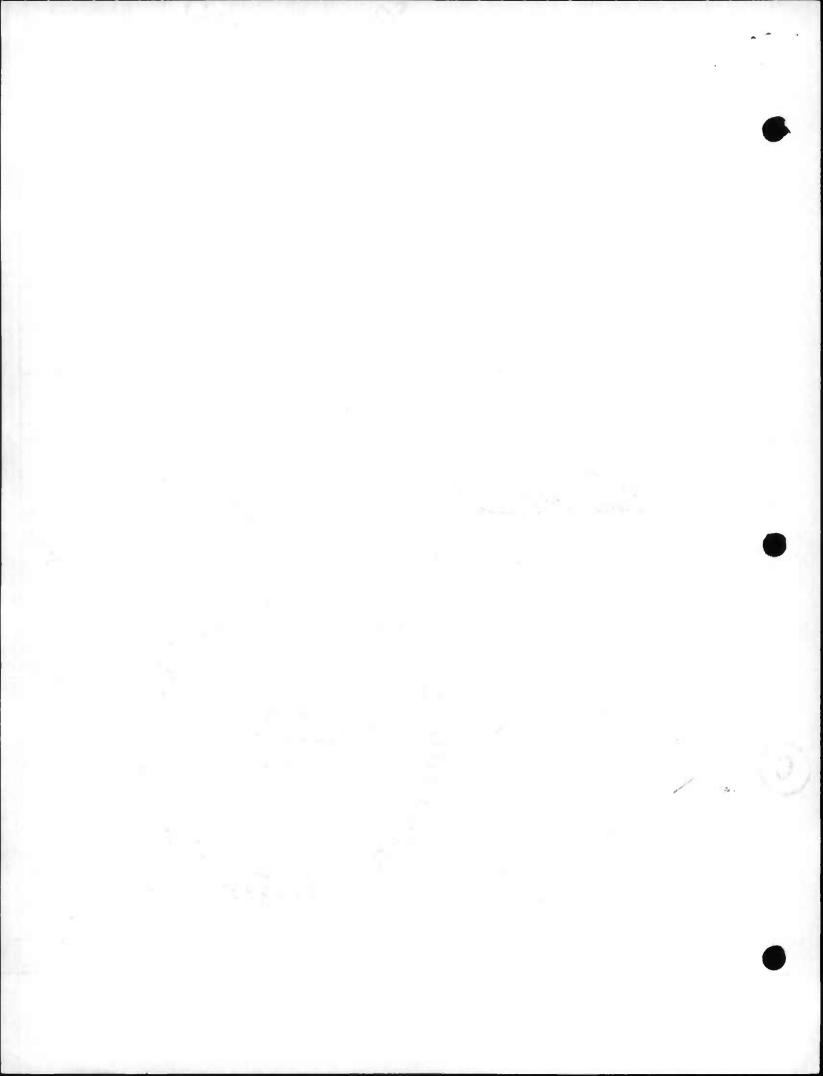
TO THE MOSPITAL DR ATTENDING PRESENT THE law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows eny Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 OF VITAL RECORDS, P.O. BOX 68760,

DIVISION

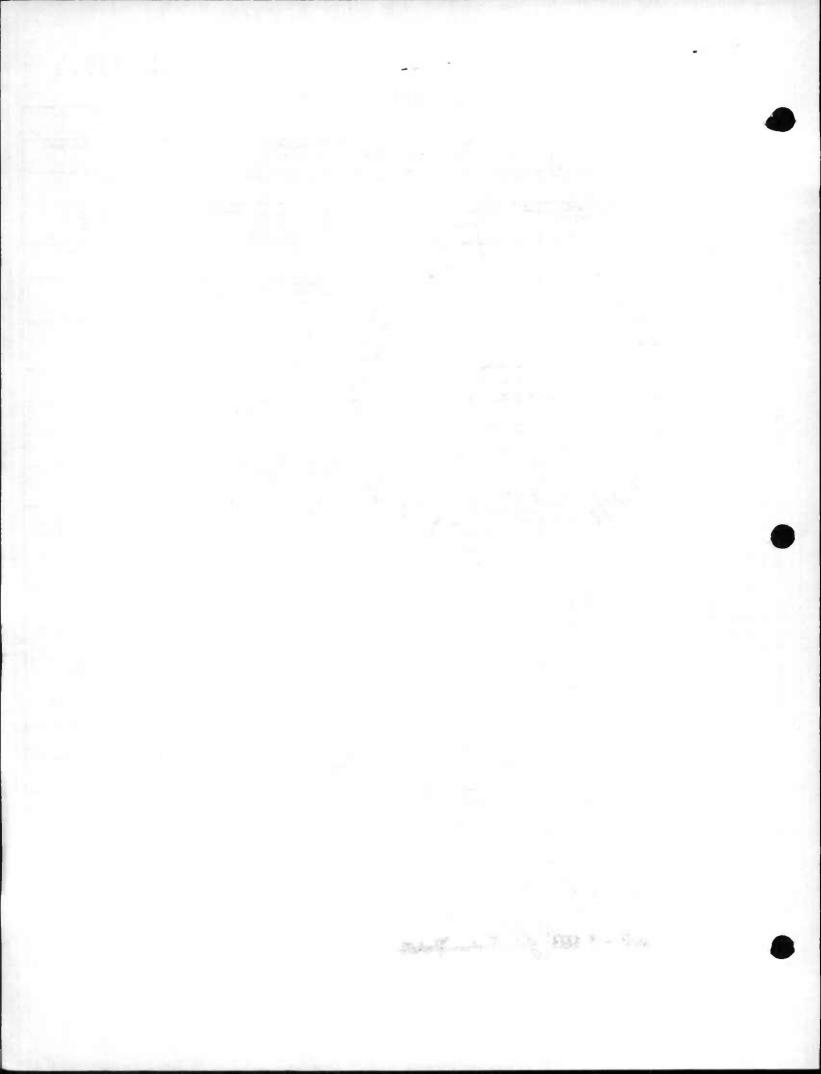
	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL HYGIENE REG. NO.		
10	1. DECEDENT'S NAME (First, Middle, Last)			D		2. DATE OF DEATH DAY	YEAR	3. TIME OF DEATH
	John Quinton 4. SOCIAL SECURITY NUMBER			ERD		3 12	93	0015 m
	The Process Hames	457 4 4 67 4	MO	HTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year)	Coun	
	216 10 1964 9a. FACILITY NAME (If not institution, give a		/6	CITY TOWAL	R LOCATION OF DE	11/6/191		aryland
DIRECTOR	PENINSULA REGION				SBURY	AIR .	WI.COM	
EC	10a. STATE 10b. COUNT	Y	10c. CITY, T	OWN OR LOCAT	ION			10d. INSIDE CITY
	Maryland W	orcester		Berl	in			LIMITS?
FUNERAL	10a. STREET AND NUMBER			101	ZIP COOE		10g. CITIZEN OF	WHAT COUNTRY?
Ä		Gull Creek F		Com	2181	.1	US	A
E.	11. MARITAL STATUS 1 Never Married 2 X Married	12. WAS DECEDENT EVER IN FORCES? 1 X YES	2 NO	13. WAS DEC	ENDENT OF HISPANI scify Cuban, Mexican	IC ORIGIN? (Specify Yes on, Puerto Rican, etc.)	r No- 14. RAC Blac	E — American Indian, ik, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D			2XXNO Specify:		Spec	White
ETED	15. DECEDENT'S EDU (Specify only highest grade	UCATION	16a, DECEDENT'S USE	UAL OCCUPATION	N	16b. KIND OF BUSI		WIITCE
H_	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use re	tired.)				
COMPL	12		Manager	of Test	ting	Md. Dept	of Ag	riculture
ပ္ပ	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Meiden S	ımame)	
8	Harry W. Pe	raue	I monitorio			ie Holloway		
2	Edith C. Perdue		Gull Cr	press (Street a	nd Number or Aural A tirement.	oute Number, City or Town, Apt. 107,	State, Zip Code) Rerlin	.Md.21811
1	20s. METHOD OF DISPOSITION	206	PLACEANDDATEOFD				ITION — City or To	
- {	1 X Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	noval from State cam	netary, crematory or other. Whatcoat M	eth. Co	emetery	1	-	Maryland
1	21. SIGNATURE OF FUNERAL SERVICE LI			-	ADDRESS OF FAC	Home		-
	Homes Of	4//				n St., Snow	Hill.	Md. 21863
	23 PART I. Enter the diseases, or	complications that caused	the deeth. Do not					Approximate
	IMMEDIATE CAUSE (Finel	List only one ceuse on e	Abdomin					Interval Between Onset and Death
	disease or condition resulting in death)	a. Ruptured, DUE TO (DR AS A	Aprtic		rysm			5hrs.
		DUE TO (DR AS A	CONSEQUENCE OF):					
S S	Sequentially list conditions,	b DUE TO (OR AS A	CONSEDUENCE OF):					
A	if sny, leading to immediate cause. Enter UNDERLYING							- 4
RTIFICATION	CAUSE (Disease or Injury that initiated events	OUE TO (DR AS A	CONSEDUENCE OF):					
	resulting in death) LAST	4						
		•						
ا پ	PART II. Other significent condition	ns contributing to death b	ut not resulting in t	he underlying	ceuse given in f			D. WERE AUTOPSY FINDINGS
		1						AVAILABLE PRIOR TO COMPLETION OF CAUSE
	0	1						AVAILABLE PRIOR TO
N: MEDICAL	Carotil	tery dise	ase (AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	Carotil	tery dise	ase (Congest Case		PERFORM FRINGE YES 2 [AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	Carotid Chronic Obstrue 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 13-YES 2 NO	HOSPITAL: 1 Chapter 2 ER/Outp	ASE (Congest Case 26, PL THER: Nursing Home	ACE OF DEATH (Cho	PERFORM YES 2 [ck only one) 6 Other (Specify)	ED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	Caroted Chronic Obstrue 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	tery dise	ase (26. PL THER: Nursing Hom F 28c. INJI	ACE OF OEATH (Cho	PERFORM 1 YES 2 [ED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN: MEDIC	Carotid Chronic Obstruct 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 19-VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	HOSPITAL: 1 Clapstiont 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year)	Petient 3 DOA 4 DOA 1 DO	26. PL THER: Nursing Hom WO 1 U	ACE OF OEATH (Cho. 5 G Residence (INT) ATT ACE OF OEATH (Cho. 10 TO THE Cho. 11 TO THE CHO. 12 TO THE CHO.	PERFORM 1 YES 2 [ck only one) 8 Other (Specify) 28d. DESCRIBE HOW IN.	URY OCCURED	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDIC	Carotid Chronic Obstruct 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 19 TES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	HOSPITAL: 1 Clapstiont 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year)	Detient 3 DOA 4	26. PL THER: Nursing Hom WO 1 U	ACE OF OEATH (Cho. 5 G Residence (INT) ATT ACE OF OEATH (Cho. 10 TO THE Cho. 11 TO THE CHO. 12 TO THE CHO.	PERFORM YES 2 [ck only one) 6 Other (Specify)	URY OCCURED	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDIC	Carotid Chronic Obstructure Chronic Obstructu	HOSPITAL: 1 Japanient 2 ER/Outp 26a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Spec	Detient 3 DOA 4 DOA 1 DO	28. PL THER: Nursing Hom M 1 Y M, factory, office	ACE OF OEATH (Che. 5 Residence (DRY AT RES 2 NO	PERFORM YES 2 [CK only one) 6 Other (Specify) 28d. DESCRIBE HOW IN. City or Town, Stete)	URY OCCURED	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDIC	CAROTE DSTEAM CAROTE DSTEAM Chronic DSTEAM 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 © YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER Check only CERTIFYING PHYS	HOSPITAL: 1 Zhopatient 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, stc. (Spec	petient 3 DOA 4 DOA 4 DOA 1 DOA 4 DOA 1 DO	28. PL THER: Nursing Hom F	ACE OF OEATH (Che 5 Residence TRK? ES 2 NO	PERFORM YES 2 [YES 2	URY OCCURED d Number or Rural er as stated.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
COMPLETED BY PHYSICIAN: MEDIC	CAROTE DSTEAM CAROTE DSTEAM Chronic DSTEAM 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 © YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER Check only CERTIFYING PHYS	HOSPITAL: 1 General and the second	petient 3 DOA 4 DOA 4 DOA 1 DOA 4 DOA 1 DO	28. PL THER: Nursing Hom F	ACE OF OEATH (Che 5 Residence TRK? ES 2 NO	PERFORM YES 2 [VES 2	URY OCCURED d Number or Rural er as stated. due to the cause(AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
BE COMPLETED BY PHYSICIAN: MEDIC	Carotid Chronic Obstruct 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PYES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	HOSPITAL: 1 General and the second	petient 3 DOA 4 DOA 4 DOA 1 DOA 4 DOA 1 DO	28. PL THER: Nursing Hom F	ACE OF OEATH (Che 5 G Residence (DRY AT RK? ES 2 NO end place, and due to seth occured at the to	PERFORM YES 2 [VES 2	URY OCCURED d Number or Rural er as stated. due to the cause(AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
IO BE COMPLETED BY PHYSICIAN: MEDICAL	CAROTE DSTEAM CAROTE DSTEAM Chronic DSTEAM 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Per S 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER MILLIAN AND ADDRESS OF DESIGNATURE	HOSPITAL: 1 Glapstient 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, stc. (Special Control of the basis of examination in the basis o	petient 3 DOA 4 DO INJURY At home, farm, streeity) ATH (ITEM 27) (Type, Price ATH (ITEM 27) (Type, Price	26. PL THER: Nursing Hom F 28c. INJ WO 1	ACE OF OEATH (Che 5 5 Residence 10 17 17 17 17 17 17 17 17 17	PERFORM 1 YES 2 [ck only one) 8 Other (Specify) 28d. DESCRIBE HOW IN. 28f. LOCATION (Street en City or Town, Stete) to the cause(s) end mann time, date and place, end BER 3 8	URY OCCURED d Number or Rural er as stated. due to the cause(AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
BE COMPLETED BY PHYSICIAN: MEDIC	Carotia Chronic Obstruct Chronic Obstruct 25. Was case referred to medical examiner? 1 19-468 2 NO 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER Michael P. S.	HOSPITAL: 1 Glapstient 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, stc. (Special Control of the basis of examination in the basis o	Partient 3 DOA 4 D	26. PL THER: Nursing Hom F 28c. INJ WO 1	ACE OF OEATH (Che 5 5 Residence 10 17 17 17 17 17 17 17 17 17	PERFORM 1 YES 2 [ck only one) 8 Other (Specify) 28d. DESCRIBE HOW IN. 28f. LOCATION (Street en City or Town, Stete) to the cause(s) end mann time, date and place, end BER 3 8	URY OCCURED d Number or Rural er as stated. due to the cause(AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,



DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate he see signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health, and Mental Hyghene prior to burlat, cremation, or removal. IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	FOR 1 - STATE REGISTRAR	STATE OF MAR	RYLAND / DEPAR CERTIF	TMENT OF I	IEALTH AND	MENTAL HYGIEN		00717
- 17	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
- 1	Bess Oplene	POE					28, 199	
i	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. B	RTHPLACE (State or Foreign
1	233-98-9661	1 🗆 M 2 🙀 F	8] YRS.	MONTHS DAYS	HOURS MIN.	Apr. 21,		est Virginia
	Se. FACILITY NAME (If not institution, give s	street and number)		9b. CITY, TOWN	OR LOCATION OF O		9c. COUNTY C	
6	Rt. 4, Box 6260			0ak	land		Garert	t
ᇤ	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	Y	10c CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY
5	MD Ga	rrett		, , , , , , , , , , , , , , , , , , , ,	0akla	nd		LIMITS?
ادّ	10e. STREET AND NUMBER	LICCE		10	. ZIP CODE	iid	10a. CITIZEN (1 YES 2 NO
3	Rt. 4, Box 6260				2	1550		SA
FUNERAL DIRECTOR	11. MARITAL STATUS	12. WAS DECEDENT EV		13. WAS DEC		NIC ORIGIN? (Specify Yes	or No — 14, F	IACE — American Indian.
BY F	1 Never Married 2 Married	FORCES? 1 [If yes, sp	ecify Cuben, Mexico 2 NO Speci	an, Puerto Rican, etc.)		Black, White, atc.
	3 Widowed 4 Divorced							White
COMPLETED	15. OECEOENT'S EOU (Specify only highest grade	CATION completed)	16a. DECEDENT'S (Give kind of	USUAL OCCUPATION WORK done during me retired.)	ON ast of working	16b. KIND OF BU	SINESS/INDUSTR	ry .
7	Elementary/Secondary (0-12)	College (1-4 or 5+)		sewife		110		
Ž	17. FATHER'S NAME (First, Middle, Last)		nou:	sewile		Но		
	David	Digman				AME (First, Middle, Meiden		
BE	19s. INFORMANT'S NAME (Type/Print)	Digman	195 MAR INC	ACCORECE (Street	Mary	Route Number, City or Tow	Coontz	
2	Karon J. Schnabl	v				and, Maryl		550
	20a, METHOD OF DISPOSITION		20b. PLACE AND DATE				CATION — City o	
	1 N Buriet 2 Cremation 3 Rem 4 Donation 8 Other (Specify)	oval from State	Belington	ther place) Fratern	al Cem.			, West VA
- 1	21. SIGNATURE OF FUNERAL SERVICE LIN	CENSEE	zozz.igeon		D ADDRESS OF FA		TINGCOM	, west vii
	· Rulling	Wind ill.				eral Home		
	23. PART I. Enter the diseases, pr	complications that ca	used the death. Do	32	S. Secon	d St., Oak	land, M	
	snock, or neart failure.	List only one ceuse	on each line.	or enter the mo	de Di dying, suc	n as cerdiec or respi	iratory arrest,	Approximata Interval Between
1	iMMEDIATE CAUSE (Final disease or condition	т	nfluenza					Onset and Death
	resulting in death)		AS A CONSEQUENCE OF	В.				2 weeks
_			mphysema	· }-				Vacana
Ó	Sequentially list conditions, if any, leading to immediate		AS A CONSEQUENCE OF	F):			-	Years
3	cause. Enter UNDERLYING	•						ļ
Ē	CAUSE (Disease or injury that initiated events	DUE TO (OR	AS A CONSEQUENCE OF	F):				
CERTIFICATION	resulting in death) LAST	d						
AL C	PART II. Other significant condition	s contributing to dee	th but not resulting	in the underlyin	ceuse given in	Part I. 24a. WAS AN	ALITTOREY	24b. WERE AUTOPSY FINDINGS
ঠ	Multi-infarct	dementia		are arranged	g could gricin in	PERFOR	IMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
유						1 YES 2	NO 🗵	OF DEATH?
≥						-		1 YES 2 NO
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			26. PI	ACE OF DEATH (C)	neck only one)		
SIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER	Outpatient 3 DOA	OTHER:	e 5 X Residence	6 Other (Specify)		
主	27. MANNER OF DEATH	28s. DATE OF INJU		E OF 28c. INJ	URY AT	28d. DESCRIBE HOW I	NJURY OCCURE	
BY	1 Natural 5 Pending 2 Accident Investigation	(MORRIT, Day, R	INJ		RK7 /ES 2 NO			
	3 Suicide 8 Could not be	28s. PLACE OF IN. building, atc.	JURY — At home, term, a	street, factory, offic		281, LOCATION (Street a City or Town, Stete)	and Number or Ru	ral Route Number,
2	4 Homicide determined					City or lown, Stelle)		
21	29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	CIAN: To the best of my i	cnowledge, death occurre	ed at the time, data	and place, and due	to the cause(s) and mar	nner as stated.	
COMPLETED								se(s) and manner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NUI			NEO (Month, Day, Year)
H	Marga	wt No	en	2	D26			1/1993
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUSE O	F OEATH (ITEM 27) (Type,	Print)		-	,	
	Dr. Margaret Kai	ser, MD	Rt. 219-No	orth, Oa	kland, M	aryland 2	1550	
10	31. DATE FILED (Month, Day, Year) MAR - 3 1993	32 REGISTRAR'S	SIGNATURE					
0	MAIN - 0 1995	grana David	con-Hondall					
97.5								



GMN

PLETED BY FUNERAL DIRECTOR
COMF
TO BE

THE FUND ALL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should not 72 hours are death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

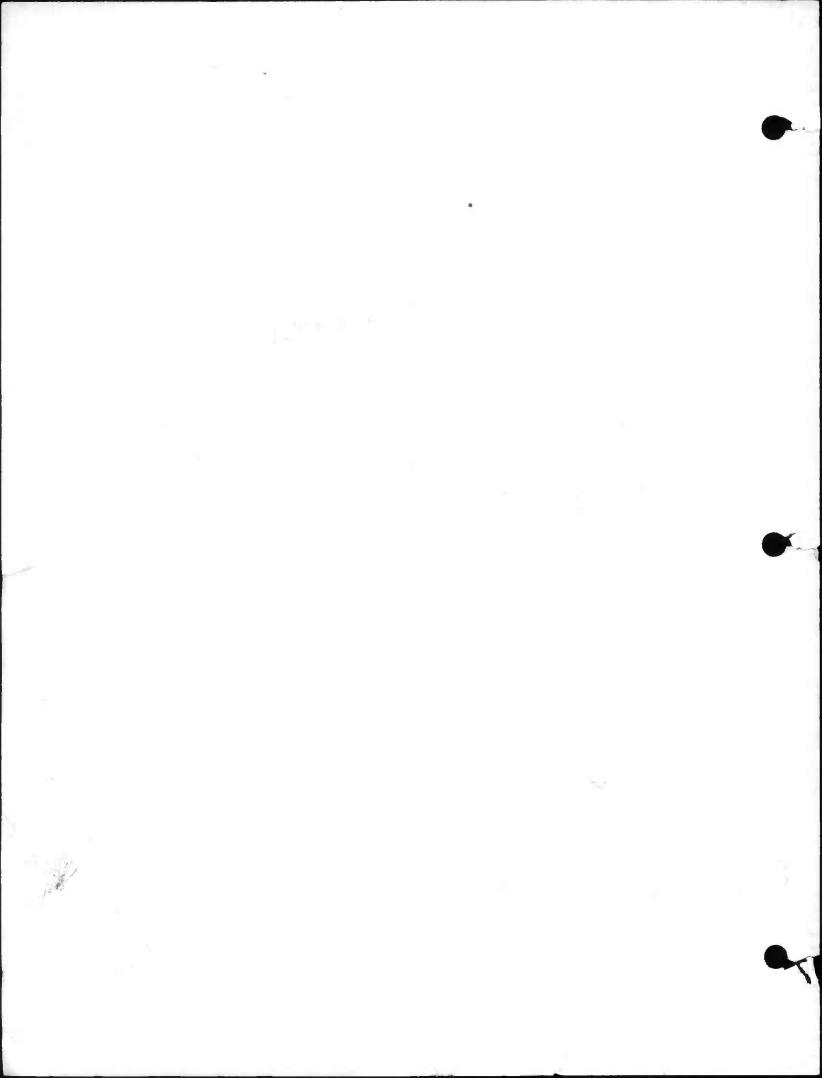
INPORTANT. II Item 28 is marked, or lifem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

21	-003 ITEMS: 23 PA	OT 1 27	חבט ו	MEO C 6	.00 /	10.10					03	0.8	3915
	FOR 1 - STATE REGISTRAR	STATE OF I			TMEN	T OF H	EALTH	AND	MENT		E	00	, , , , ,
٦	1. DECEOENT'S NAME (First, Middle, Last)			0		- 01	DEA		2. DAT	E OF DEATH			3. TIME OF DEATH
	George	Δ		Pino	lel1		r		0 3	TH DV		YEAR Q 3	3 · 34 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yr	s. lest birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DAT	E OF BIRTH		8, BIRTH	PLACE (State or Foreign
	213-94-0346	1 🛱 ¥ 2 🗆 F	28	YRS.	MONTHS	DAYS	HOURS	MIN,	pc To	BER 23	196	4 Count	ÄRYLAND
ı	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY	, TOWN C	R LOCATI	ON OF D	EATH		9c. COL	UNTY OF D	EATH
	Anne Arundel (RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT		Hosp				olis	5			Ann	e Ar	rundel
	MARYLAND ANNE	ARUNDEL			APOL		ION						10d. INSIDE CITY LIMITS? 1 YES 2 NO
	906 OLD ANNAPOLIS	NECK RD	•				ZIP CODI 1403	•			l -	S.A.	WHAT COUNTRY?
	11. MARITAL STATUS 1 Avever Merried 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2			If yes, sp		n, Maxica	n, Puerto	IN? (Specify Yea Rican, atc.)	or No—	14. RACI Black Speci BLA	
	15. DECEDENT'S EDL (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5		Give kind of the Me. Do NOT us ARPENT	work done	CCUPATIO during mo	N st of workin	g	16	b. KIND OF BUS	SINESS/IN	OUSTRY	
	17. FATHER'S NAME (First, Middle, Lest) GEORGE A. PINDELL	, SR.							ME (First,	Middle, Maiden	Sumame)		
	19a. INFORMANT'S NAME (Type/Print) GEORGES A. PINE	ELL, SR.		19b. MAILING 906 0	ADDRESS LD A	S (Street a NNAP	nd Number OLIS	or Rural NEC	Route Nur K RI	nber, City or Town	n, Stete, Zi POLI	S, M	D. 21403
	20a. METHOD OF DISPOSITION WXBurlal 2 ☐ Cremation 3 ☐ Rarr 4 ☐ Donation 5 ☐ Other (Specify)	oval from Stata		ACEAND DATE OF				/15/	1993			IS,	wn, Stata MD. 21401
	21. SIGNATURE OF FUNERAL SERVICE LI		->				D ADDRES						
	· Harry		ees		8	21 W	EST :	ST.	ANNA	TUARY, APOLIS,	MD.		01
	23. PART I. Enter the diseases, or shock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a.C.ARDIAC	ARRHY	line.	DUE_I							rreat,	Approximate interval Between Onset and Death
	Sequentially liat conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	С		NSEQUENCE OF									
	resulting in death) LAST	d											
	PART II. Other algorificent condition	a contributing to	death but n	ot reculting i	In the ur	nderlylng	ceuse g	iven in	Part I.	24a. WAS AN PERFOR 1 PYES 2	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	. 909		ОТНЕІ	₹:	ACE OF D						
	1 VES 2 NO 27. MANNER OF DEATH 1 Neturel Pending	1 ☐ Inpatient 2. 26e. DATE OF (Month, D	INJURY	26b. TIM		28c. INJ	JRY AT			er (Specify)	JURY OC	CURED	
	2 Accident Investigation 3 Suicide 6 Could not be determined	28a. PLACE O building,	F INJURY A atc. (Specify)	M homa, farm, s				,	281. LO City	CATION (Street a or Town, State)	nd Numbe	or or Rural F	Poute Number,
	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS MEDICAL EXAMINE) and manner as stated.

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) O.C.M.E. 03/09/1993 PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Penn Street, Baltimore, Maryland 21201 22. REGISTBAR'S SIGNATURE Fishe Davidson-Randelle



(DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146
SOH 3 THE HOS	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-nours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUN	TO THE FUNERAL DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Debt. of Health and Mental Mygiene prior to burial, cremation, or removal.
IMPORTAN	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF MARYL	LAND / DEPA CERTI		HEALTH AND	MENIA	REG. NO.	93	3 08916	
1. DECEDENT'S NAME (First, Middle, Last	Eva Betty		adver		Mar				
4. SOCIAL SECURITY NUMBER 272-34-5734		(In yrs. last birthda	MONTHS	YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE (Mont	OF BIRTH 2 2 7	0.	BIRTHPLACE (State or Foreign Country)	
9a. FACILITY NAME (If not institution, give Garrett County 1		oital		TOWN OR LOCATION OF	OEATH		9c. COUNTY	of OEATH arrett	
RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	iTY	10c. (CITY, TOWN OR	LOCATION				10d. INSIDE CITY	
	Preston			Terr	a Alt	ia.		LIMITS?	
10e. STREET AND NUMBER	10e. STREET AND NUMBER				64		10g. CITIZEN	ZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 200	11 1	AS DECENDENT OF HISP yes, specify Cuban, Maxi YES 2 NO Spe	cen, Puerto		or No 14.	RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S Et (Specify only highest gra Elementary/Secondary (0-12)	DUCATION ide completed) College (1-4 or 5 +)	(Give kind life. Do NO		CUPATION ring most of working	164	b. KIND OF BUS			
17. FATHER'S NAME (First, Middle, Lest) John Upperman		Hous	ewife		NAME (First,	Middle, Maiden	Domest	tic	
199. INFORMANT'S NAME (Type/Print) Jacqueline M. Me	oats			Street and Number or Run Ave. Terra	al Route Nun	nber, City or Town		de)	
20a. METHOD OF DISPOSITION 1 Serial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	(Name of cemetery, cremetory or 20c. LOCATION — City or Town, State Alta Cemetery Terra Alta, W.V								
21. SIGNATURE OF FUHERAL SERVICE	1 . //	_	22. N/	AME AND ADDRESS OF	FACILITY	Funers	1 Home	e. Inc.	
23. PART I. Enter the diseeses, o shock, or heert failure	or complications that cause re. List only one cause on		10 to not enter the	he mode of dying, s	AVO.	. Terra	Alta ratory arrest	Approximete Interval Between	
23. PART I. Enter the diseesea, o	e. List only one cause on o		10 o not enter the corp. E orp.	5 Highland	AVO.	. Terra	Alta ratory arrest	Approximete Interval Between	
23. PART I. Enter the diseases, o shock, or heert failure immediate cause or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	BUE TO (OR AS	A CONSEQUENCE A CONSEQUENCE A CONSEQUENCE	10 no not enter the corp.	5 <u>Highland</u> he mode of dying, si	NVe uch as cer	. Terra	AUTOPSY IMED?	Approximete Interval Betwoonset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De	
23. PART I. Enter the diseases, o shock, or heert failur immediate cause or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions of the condition of the cond	DUE TO (OR AS DU	A CONSEQUENCE A CONSEQUENCE A CONSEQUENCE	10 no not enter the corp.	5 <u>Highland</u> he mode of dying, si	i Ave.	Terra rdiec or respi	AUTOPSY IMED?	Approximete Intervel Betwo Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De Onset and De	
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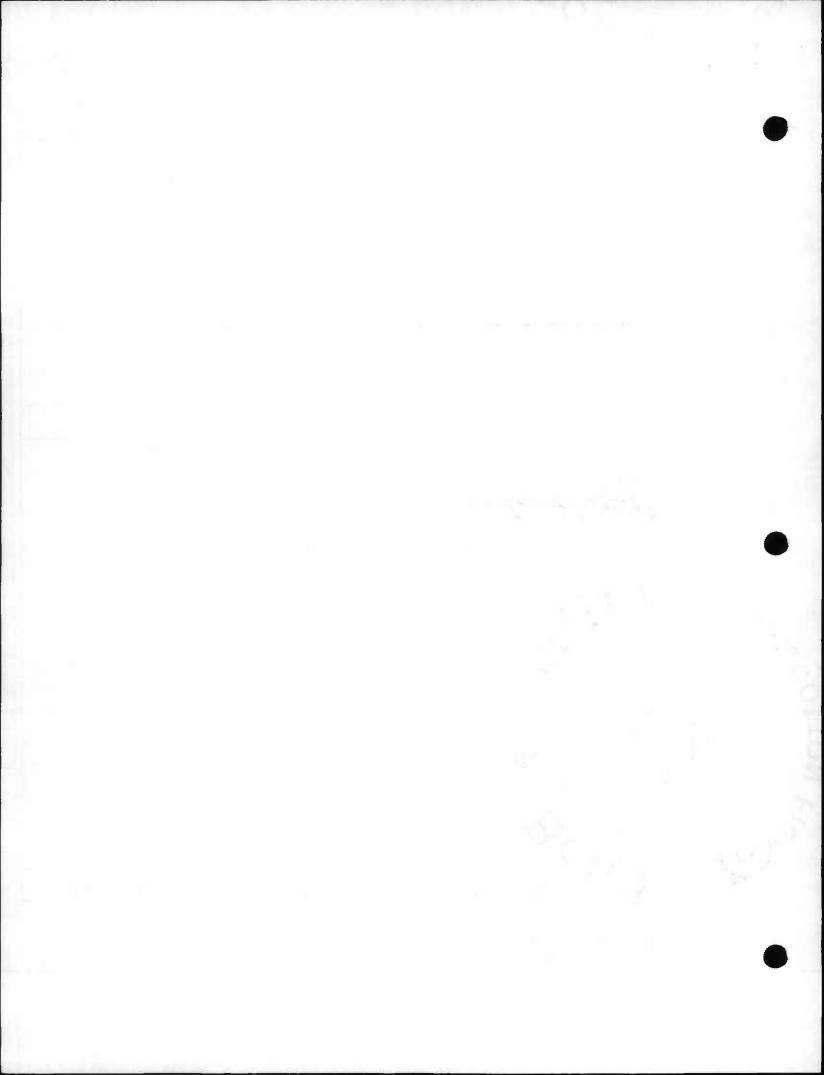
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 2. DATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR Minnie Frances Quillen March 1993 5:45 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 1 🗌 M 2 📈 F YRS. 212-16-1927 April 25 1913 MD permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Worcester MD Berlin 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 10688 Worcester Hwy USA 21811 Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 XNO 1 Never Married 2 Marri Specify: White 1 TES 2 NO Specify: BY 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Q Elementary/Secondary (0-12) College (1-4 or 5+) detached 8 Poultry grower Farming 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) H page 5 should be Frank Outten BE Cora Lee Merritt notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Dorothy Hastings 10688 Worcester Hwy. Berlin. _Md 21811 9 20a. METHOD OF DISPOSITION

1 Description | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | Management | 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE director, must Riverside Cemetery 3/9/93 Berlin, Md. 21. SIGNATURE OF SUINE BALL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY funeral Burbage Funeral Home, 108 Williams St. Berlin, Md. the 21811 medical Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. in by Approximata Interval Between 5 IMMEDIATE CAUSE (Final **Onset and Death** and completely fille burial, cremation, or other traumatic event, the disease or condition_ ardiac resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OF AS A CONSEQUENCE OF) 2 if any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hyglene prior to nT CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF). that initiated events resulting in death) LAST Item 23 shows any injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24s. WAS AN AUTOPSY signed by the 1 YES 2 NO 1 YES 2 NO been 1. of PHYSICIAN: has be 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate to the State HOSPITAL:
| Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) marked, or 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this (1 Natural 5 Pending 1 YES 2 NO BY After 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) . 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED afte. 4 Homicide 28 29a. CERTIFIER

(Chack only

CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, de ath occured at the time, data and place, and due to the cause(s) and menner as stated. 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE 3 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 21801 Wieland MD 560 DR. BIUI Miverside, 32. REGISTRAR'S SIGNATURE



FOR STATE REGISTRAR

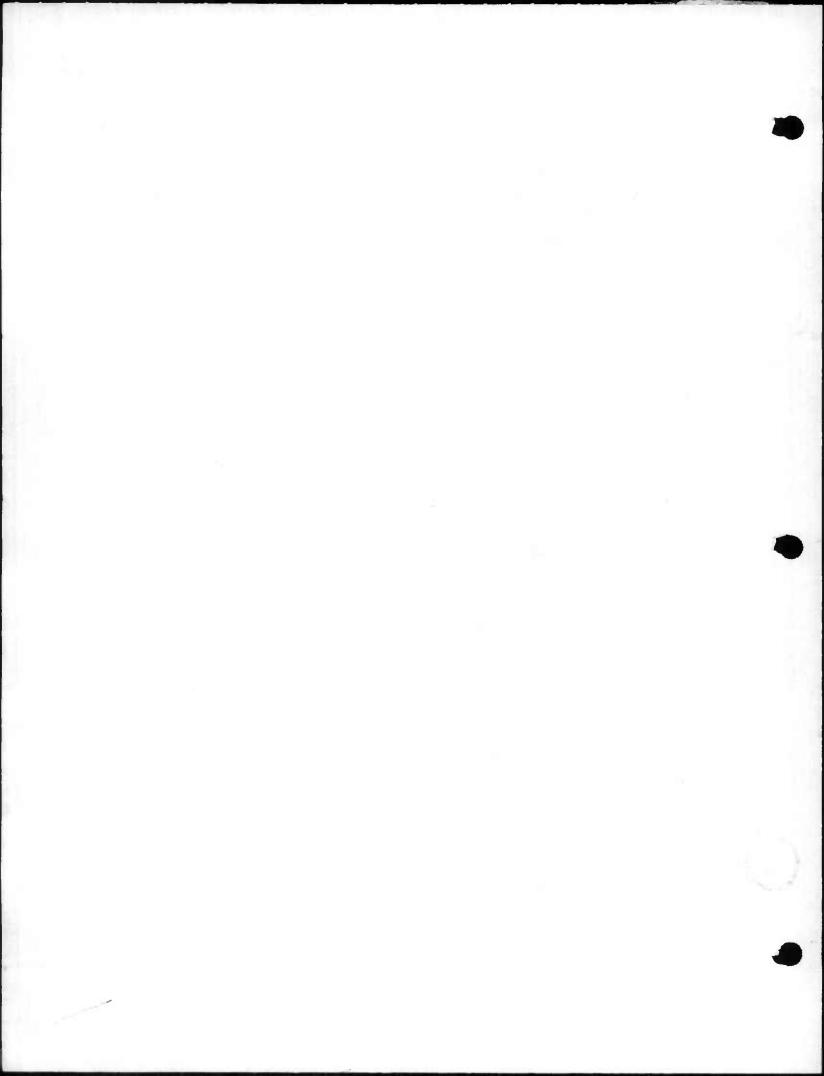
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DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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Z		4. SOCIAL SECURITY NUMB	1 100			IF UNDER	1 YEAR	HOURS	MIN.	(Mont)	ATE OF BIRTH Aorith, Day, Year)		Count	ry)	(State or Fi	oreign		
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DR.	DIR	MARYLAND MONTGOMERY ROC							LE								YES 2 X	NO
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- 1	필			5+		ATTO	ORNI	EY					CLAIMS					
OUC	COMPL	17. FATHER'S NAME (First, M	liddle, Last)							18. MOT	HER'S NA	AME (First,	Middle, Maiden	Surname)				
to D	BE (JACK RUBINS	STEIN							FLO	RENC	CE F	RIEDMA	N				
E I	0	19e. INFORMANT'S NAME (7											ber, City or Tow					
9		MAXINE RUBIN		(WIFE)	1						_		LLE, M		0850			
examiner must be notified at once.	- 1	20a. METHOD OF DISPOSIT 1 ↑ Burlet 2 ↑ Cremetic	n 3 N Rem	lovel from State	0	ther place)								CATION -				
E L		4 Donation 6 Other (Specify) TEMPLE BETH EL 21. SIGNATURE OF FUNERAL SERVICE LICENSEE									CEMETERY DAVIE, FLORIDA AME AND ADDRESS OF FACILITY							
E E													G MEMO	RIAL	CHA	PEL	S, I	NC.
a ex		23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac pr respiratory errest, Approxi																
medical				List only one ca			1. РО Г	ot ente	r the mo	ode of dy	/ing, su	cn es cer	alec or reep	eratory e	rreet,	- 6	Approxin	Between
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any Injury.	LC	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS																
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0r 15	YSI	1 VES 2 NO		1 Inpatient 2	ER/Outpat					me 6 🗆 F	Residence	6 🗆 Oth	er (Specify)					
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28 ls	E	3 Suicide 8 4 Homicide	Could not be determined	buildin	OF INJURY - g, etc. (Specif)	y)	i, raimi,	street, te	стогу, отн	ce			CATION (Street or Town, State		er or murai	House h	vumber,	
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2	2	30. NAME AND ADDRESS O	F PERSON W	/				, Print)	_	, n	1170	_		I M	IARCE	1 13	3,199	3
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typos, Print) MICHAEL BLUNDA 106 IRVING STREET N.W. #208 WASHINGTON D.C. 20010																

32 REGISTRAR'S SIGNATURE
Guida Davidson Randelle

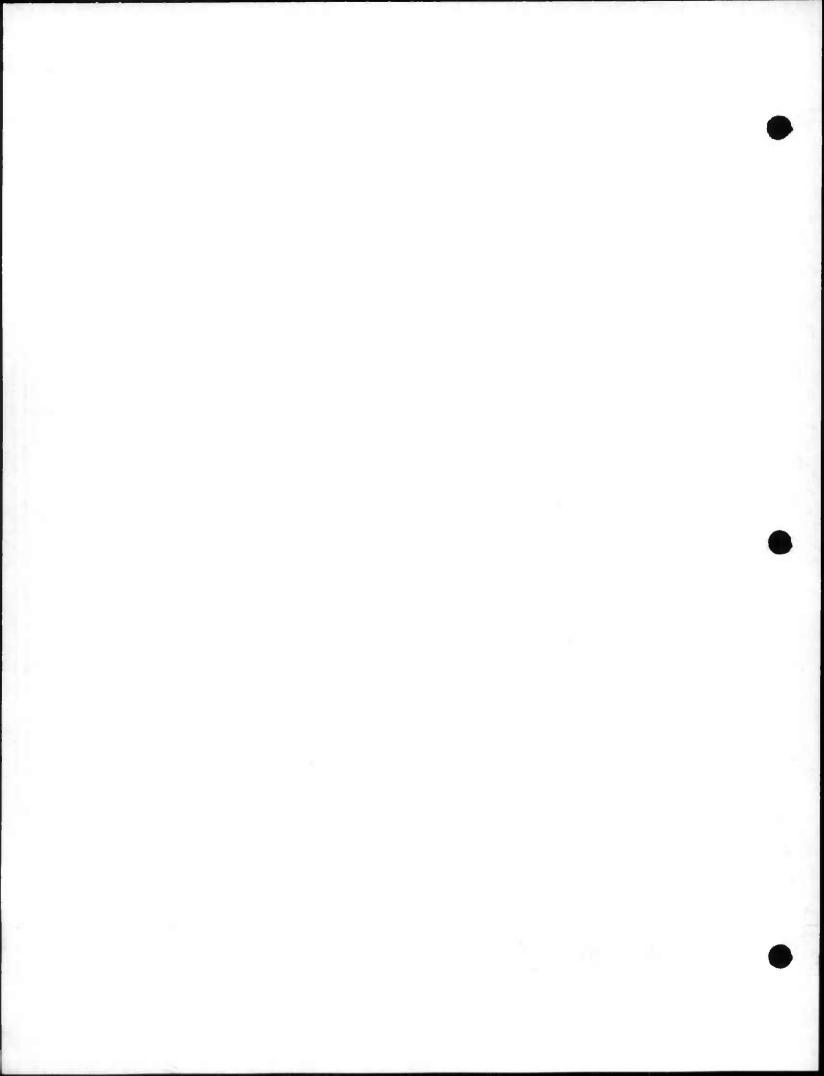
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



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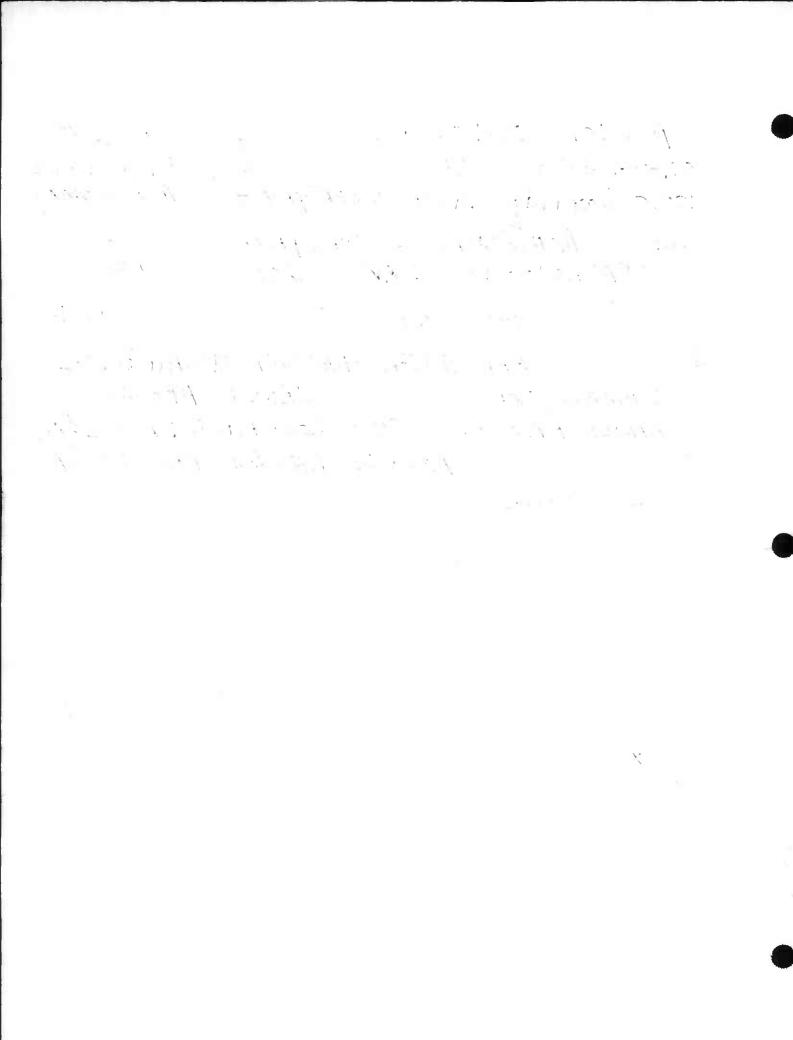
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_	1 - FOR STATE REGISTRAR	STATE OF MARY	YLAND / DEPAI CERTIF	RTMENT OF	HEALTH AND	MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last)	-144	R 4	26.	4/200	2. DATE OF DEATH MONTH	W 97	3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER 218-96-2530	5. SEX 8. AC	GE (In yrs. last birthday) 9 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) Feb. 26		BIRTHPLACE (State or Foreign Country)				
OR	9a. FACILITY NAME (If not institution, give s 3003 Ferndale Str	eet		% CITY, TOWN	or Location of D	DEATH	9c. COUNTY OF DEATH Montgomery					
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Montg			10d. INSIDE CITY LIMITS?								
FUNERAL	10e. STREET AND NUMBER 3003 Ferndale St			ensingto	01. ZIP CODE 20895		10g. CITIZEN	1 YES 2 NO				
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS OECEDENT EVE FORCES? 1 1 YE IF YES, GIVE WAR OF	ES 2 NO	If yes, a	CENDENT OF HISPA	ANIC ORIGIN? (Specify Yesten, Puerto Rican, etc.)		RACE — American Indian, Block, White, etc. Specify White				
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16s. DECEDENT'S (Give kind of life. Do NOT u	work done during n	ION post of working	16b. KIND OF BU	SINESS/INDUST					
	12 17. FATHER'S NAME (First, Middle, Last) Ilyia Paramon	2017	Booke	eper		AME (First, Middle, Maiden		Design Ins				
TO BE	Ilyia Paramon 190. INFORMANT'S NAME (Type/Print) Galina Johnson	110 V			and Number or Rural	Known I Route Number, City or Tow						
	20e. METHOD OF DISPOSITION 1	gyel from State	20b. PLACE AND DATE	OF DISPOSITION /A	leme of	DATE 20c. LO	CATION — City	or Town, State				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Commetter & Commetter											
CERTIFICATION	iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS	S A CONSEQUENCE OF	F): -):	S Car 6	10 D	02	Onset and D				
MEDICAL	PART II. Other significant condition	s contributing to death	but not resulting	n the underlyin	ng cause given in	Pert I. 24a. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FIND AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO				
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	utpatient 3 DOA	28. P OTHER: 4 □ Nursing Hor	LACE OF DEATH (C)							
зу РНУ	27. MANNER OF-DEATH Netural 5 Pending Accident Investigation	28a. DATE OF INJUR (Month, Day, Year	Y 28b. TIM	E OF 28c. IN.	JURY AT ORK? YES 2 NO	8 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCURE	70				
ETED B	3 Suicide 8 Could not be determined	28a. PLACE OF INJUI building, atc. (Sp	RY — At home, farm, a pecify)	treet, tectory, offic								
COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC THEOLOGY EXAMINER	CIAN: To the best of my kno	owledge, death occurre	d at the time, data	and place, and due	a to the cause(a) and man	ner as stated.	use(a) and manner as state				
BE	290. SIGNATURE AND TITLE OF CERTIFIER			2	290. LICENSE NUI			SNED (Month, Day, Year)				
2	30. NAME AND ADDRESS OF PERSON WING	COMPLETED CAUSE OF D	DEATH (ITEM 27) (Type,		(8 les	Sons	12	Solle				
	31. DATE FILED (Month, Dey, Year) MAR 17 '93	32. REGISTRAR'S SIG	SNATURE SOME SOME SOME SOME SOME SOME SOME SOM	5-				NOC				



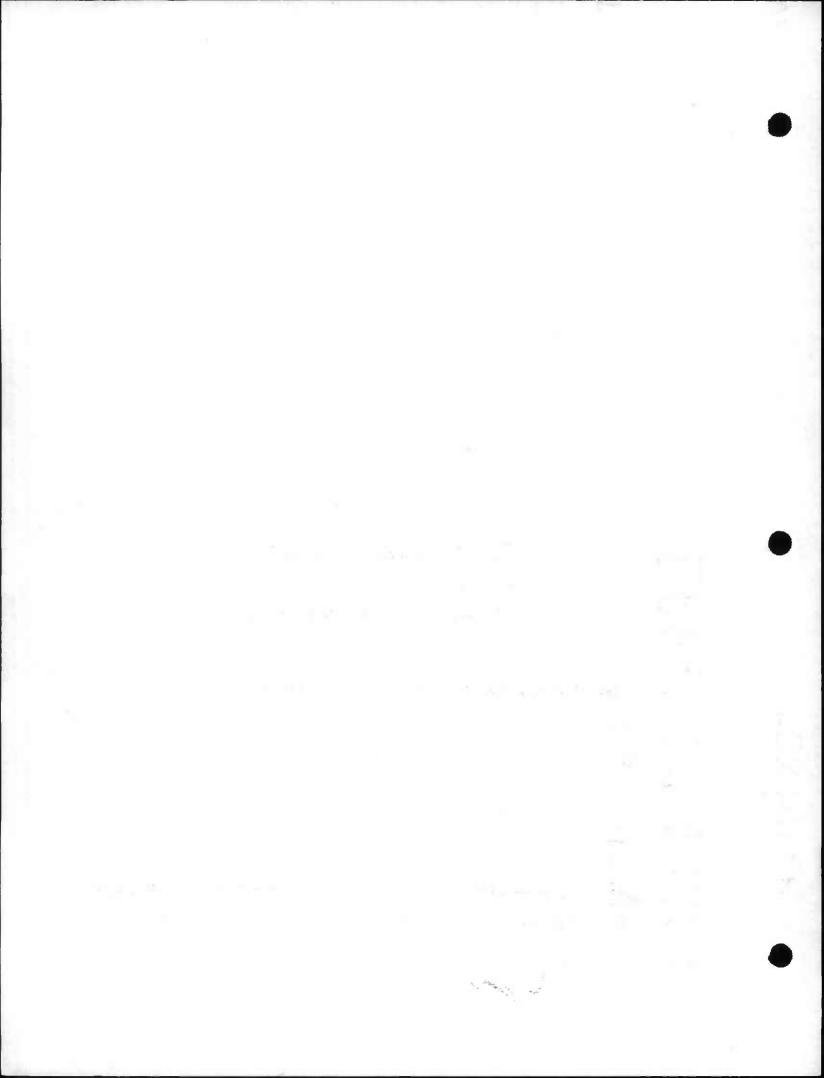
FOR 1 STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)) RADOVSKY 2. DATE OF DEATH MONTH DAY YEAR 2 A M							
1	4. SOCIÁL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) F. UNDER 1 YEAR IF UNDER 24 HRS. O26-05-6455 1.24 = 2 F							
IOR	90. FACILITY NAME (If not institution, give street and number) 10710 Lock ridge Drive Sylver Spring PRING 9c. COUNTY OF DEATH 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Spring 10710 Lock ridge Drive Sylver Sylver Sylver Spring 10710 Lock ridge Drive Sylver							
DIRECTOR	100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION 100. LIMITS? NON GOMERY SYLVER SPRING 100. WAS 2 \(\text{IMITS?} \)							
FUNERAL	100. STREET AND NUMBER 101. ZIP CODE 2090/ 10g. CITIZEN OF WHAT COUNTRY?							
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Mexicen, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, atc. Specify: Use in U.S. ARMED 14. RACE — American Indian, Black, White, atc. Specify: Use in U.S. ARMED 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Mexicen, Puarto Rican, etc.)							
	15. DECEOENT'S EDUCATION (Specify only highest grade completed) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working							
P.E.	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 3 VRAPS MATOR — NAV IGATOR U.S. Air Force.							
COMPLETED	17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Symeme)							
BE (SAMUEL KADOVSKY JENNIE ABRAMS 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201. Day							
2	FRANCES RADOVSKY 10710 LOCKRIDGE DR SS2901							
	20c. METNOD OF DISPOSITION 1 Suriel 2 Cremetion 3 Removal from State 4 Danation 5 Other (Specify) 20c. LOCATION - City or Town, State ARLINGTON ARLINGTON ARLINGTON							
	21. SIGNATURE OF POWERAL SERVICE LICENSEE 22. NAME AND ADDRÉSS OF FACILITY DUNZANSKY GOLDBOTC MEMORIAL CHAPELS 1170 Ros Hall M. PK Rock Ills. MD							
	23. PART i. Enter the diseases, or complications that caused the death. Do not snter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one cause on such line.							
	IMMEDIATE CAUSE (Fine) disease or condition resulting in desth) a. G LIOBLASTOMA Onset and Death H Mon							
	resulting in dasth) DUE TO (OR AS A CONSEQUENCE OF):							
NO O	Sequentially list conditions, Out to (or as Aconsequence of):							
CERTIFICATION	If any, leading to immediats cause, Entar UNDERLYING c. A PhASIA							
	that initiated events resulting in death) LAST							
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS							
EDICAL	PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OPERATH?							
	1 □ YES 2 NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF OEATH (Check only one) 27. MANNER OF DEATN 28. DATE OF INJURY 28. DATE OF INJURY 28. TIME OF 1. MORK? 28. INJURY AT 28. DATE OF INJURY 28. INJURY AT WORK?								
EXAMINER? 1 YES 2 NO EXAMINER? 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Recidence 6 Other (Specify)								
TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide determined 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
Solution to be determined building, etc. (Specify) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated.								
S C C	one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner as stated.							
8	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Disk, Year) 29d. DATE SIGNED (Month, Disk, Year)							
임	30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)							
	PETER SHERER, MD - 3947 FERRARA DRIVE - WHEATON, MARYLAND 20906 31. OATE FILEO (Month, Day, Vear) 32, REGISTRAR'S SIGNATURE							
	MAR 16 93 Julia Devidoon Rondelle							



ITTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.	TITH: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
HENDERAL OR ATTENDING PHYSICI	IE PLINERAE DIRECTOR: After this cer	d'annun'72 hours after death with th	RTANT: If item 28 is marked, o

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR					MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIM										3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5.	in yrs. lest birthday)	IF UNDER	1 7540	IF UNDER	-	March 11, 1993			4:00 p. M	
		□ M 2 1 86		MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	1006	Count	ry)
	9a. FACILITY NAME (If not institution, give street	A 00)	9b, CITY	TOWN O	R LOCATIO	ON OF DE			Was	hington, D.C
Œ	Sacred Heart Home							Desir		Coomoolo	
8	RESIDENCE OF DECEDENT				tsvi				Prii	ice	George's
DIRECTOR	10s. STATE 10b. COUNTY	10c. CIT	Y, TOWN	OR LOCATI	ION					10d. INSIDE CITY LIMITS?	
	Maryland Montgor	Gai	thers							1 X YES 2 NO	
FUNERAL	10e. STREET AND NUMBER			101.	ZIP CODE			10g. CIT	IZEN OF	WHAT COUNTRY?	
<u> </u>	19320 Dunbridge Way				<u>0879</u>			U.S			
	11. MARITAL STATUS 1: 1 Never Married 2 Married	2. WAS DECEDENT EVER IF FORCES? 1 YES	2 V NO		If yes, spe	cify Cuba	n, Maxica	IC ORIGIN? (Specify Yen, Puerto Rican, atc.)	s or No—	Blac	E — American Indian, k, Whita, etc.
BY	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR DA	ATES"		1 TYES	2 X NO	Specify	*		Spec	White
	15. DECEDENT'S EDUCAT		16a. DECEDENT'S	USUAL O	CCUPATIO	N		16b, KIND OF BU	SINESS/INC	DUSTRY	***************************************
<u> </u>	(Specify only highest grade cor Elementary/Secondary (0-12)	npierea) College (1-4 or 5+)	(Give kind of life. Do NOT u	work done se retired.)	during mos	BE OF WORKE	g				
를		3	Switchb	pard	Oper	cator		Residen	tial	Com	munity
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					16, MOTI	IER'S NA	ME (First, Middle, Maiden	Sumame)		
BE	Charles Mortimer Re	ed						izabeth De			
2	19e. INFORMANT'S NAME (Type/Print)							Route Number, City or Tox			
	Cherie M. Degnan			_			ıy, (Gaithersbu			
	20a. METHOD OF DISPOSITION 1 ☑ Burlel 2 ☐ Cremation 3 ☐ Remove	of from State	cemetary, cremator Sh St.	or other	position place	(Name	m	3/18 A1e			
	4 Donation 5 Other (Specify)		ish st.			D ADDRE			xanu	ııa,	VA.
	DA1 0 0	Ci0.0						DeVo1			
	Trechart,	J. 0209	Lans								g, MD. 20877
	23. PART I. Enter the diseesee, or con ahock, or heart failure. Lis			not enter	the mo	de of dy	ing, suc	h as cardiac or resp	iratory ar	rest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition Cardina and Cardina an										
	disease or condition a. Cardio pulmonary arrest Due to (or as a consequence of):										
	DUE TO (OR AS A CONSEQUENCE OF): Preumonia.										
0	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
SAT	cause. Enter UNDERLYING Charic Obstructive Pubman Dingse.										
Ē	CAUSE (Disease or Injury that initiated events	CONSEQUENCE	UENCE OF):								
CERTIFICATION	resulting in death) LAST		- 1								
	PART ii. Other eignificent conditions	contributing to deeth t	out not resulting	in the u	nderivino	cause	alven in	Part I. 24s. WAS A	AUTOPSY	24	b. WERE AUTOPSY FINDINGS
BY PHYSICIAN: MEDICAL		appropriate							RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
	8101010	CPP1 Jacob	. ,. ,, .	1101		100		1 🗆 YES	2 740		OF DEATH?
2	() ()							_			1 TYES 2 NO
IAN	25. WAS CASE REFERRED TO MEDICAL				26. PL	ACE OF D	EATH (Ch	eck only one)			
SIC		IOSPITAL:	petient 3 DOA	OTHE		e 5 □ R	esidence	6 ☐ Other (Specify)			
H	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	26b. Til		28c. INJ			26d. DESCRIBE HOW	INJURY OC	CUREO	
∀	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Idar)	"	M		YES 2	_ NO				
	3 Suicide 8 Could not be	— At home, farm,	street, fac	tory, offic	•		28f. LOCATION (Street City or Town, State	and Numbe	or or Runal	Route Number,	
TE	4 Homicide determined building, stc. (Specify) City or Town, State)										
PLE	29a. CERTIFIER (Check only Ch										
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated.										
ш	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LIC	ENSE NUI	MBER	29d. DA	TE SIGNE	D (Month, Day, Year)
0	SET	ms				D	3>	934		3/1	2/93
5	30. NAME AND ADDRESS OF PERSON WHO		EATH (ITEM 27) (Typ	e, Print)			_	934 to Dire	0.)	242
	Stephenie Trife	18/10/ ND	1300	Co	een	rag-	(en	the 12 Me	טאיפי	n se	0110
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	LATURE								
	MAR 19 '93	Julia Davidson	Mandell								



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

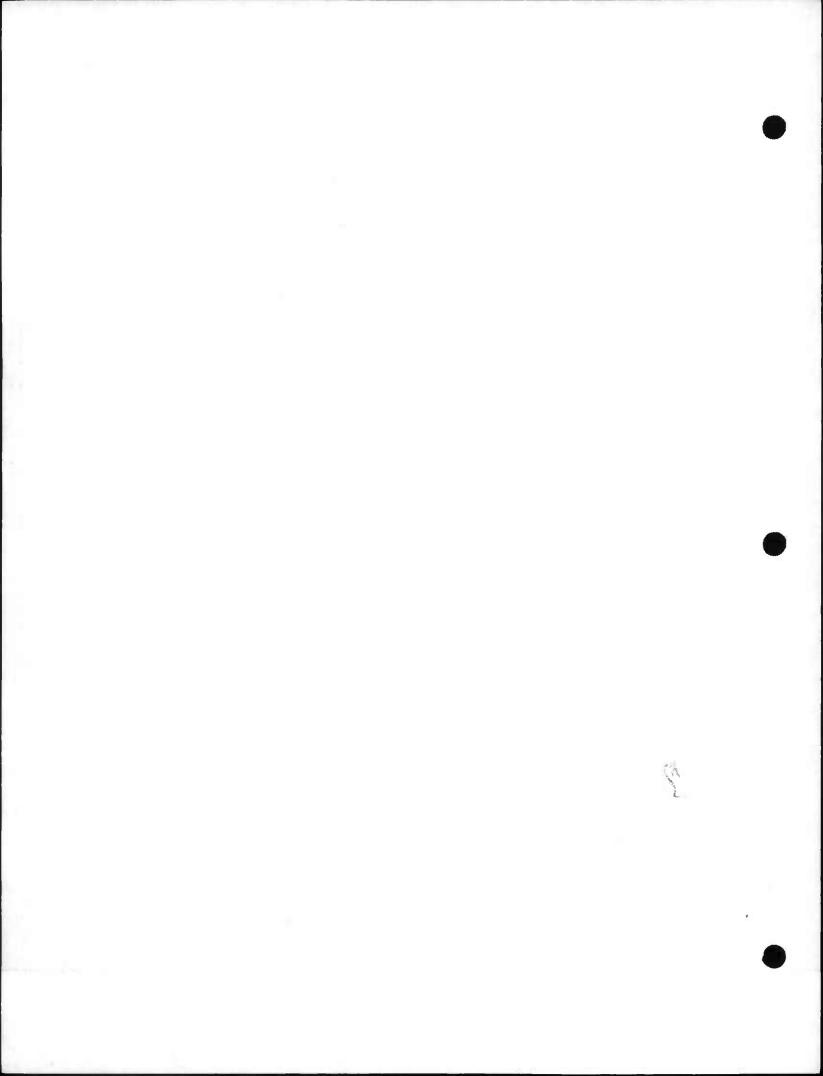
A ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral directio, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Dept. of Health and Memai Hygiene prior to burial, cremation, or removal.

If them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

						TOATT		DEA		HEG. I	O.		
(allege - Valence										2. DATE OF DEATH MONTH MARCH	3. TIME OF DEATH //38P, M		
	4. SOCIAL SECURITY NUMBER		S. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDER	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		8. BIRTHP	LACE (State or Foreign
	517-52-13	00	1 M 2 F	79	YRS.	MONTHS	DAYS HOURS MHM. (Morth, Day, Year) Country) Washin						
	9a. FACILITY NAME (If not institu	ution, give stree	et and number)			9b. CITY	, TOWN	OR LOCATI	ON OF DE	ATH	9c. CO	UNTY OF DE	
DIRECTOR	Anne Arundel	Hospi	tal			Aı	nap	olis			Ann	e Aru	nde1
[[[RESIDENCE OF DECE	DENT b. COUNTY			10c CIT	Y, TOWN	OR LOCAT	DOM:					10d, INSIDE CITY
E	Maryland	Anno A	Arundel			napo.		ion					LIMITS?
	10e. STREET AND NUMBER	mile A	itundet		All	паро.	-	. ZIP COD	F		100 0		1 X YES 2 NO
5	1000 Sextant	Court					- 1	2140				S.A.	IAI COOMINI?
FUNERAL	11. MARITAL STATUS		2. WAS DECEDEN			13.	WAS DEC			C ORIGIN? (Specify			- American Indian
	1 Never Married 2 Ma		FORCES? 1	YES 2 X	∮NO	- 1	if yes, sp	ecify Cube	n, Mexican Specify:	, Puerto Rican, etc.)		Black, Specify	- American Indian, White, etc.
BY	3 Wildowed 4 Divorce	d							op comy.			whit	e
COMPLETED	15. DECEDI (Specify only hi	ENT'S EDUCAT ghest grade co		(ECEDENT'S Give kind of	work done			19	16b, KIND OF	BUSINESS/IN	DUSTRY	
<u>"</u>	Elementary/Secondary (0-12)	College (1-4 or 5	•)	₩. Do NOT u								
N N	12 17. FATHER'S NAME (First, Middl			hc	usew	ite		T			n hom		
		,,								AE (First, Middle, Maid	en Sumame)		
BE	James Fitzge		_	1,	OF MAILING	ADDRES	P (Charles	1		Griffin			
5	Joanne Gore	, taky								oute Number, City or upolis, M			
	20a. METHOD OF DISPOSITION				AND DATE				Airiid	DATE 20c.			n State
	1 X Burlei 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		il from State	Cemetery, c	ematory or o	ther place)	nete	rv 1	Mar.	17.93 W	ashin	oton.	D.C.
	12 Burlei 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Mt. Olivet Cemetery Mar. 17,93 Washington 21. SIGNATURE OF FUNERAL SERVICE DEBSEE 22 NAME AND ADDRESS OF FACILITY DeVol Funeral Home										500,	2101	
	2222 Wisconsin Ave., N.W., Wash., DC											DC 20007	
23. PARTVI. Enter the diseases, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest.											Approximate		
1 1	shock, or hear	t failure. Lie	it only one cau	ise Dn each lin	ie.	100					principly a	11001,	Interval Between
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)												
	resulting in death) a. And the transct DUE TO (OR AS A CONSEQUENCE OF):												
2	Marcardial Introvition												
CERTIFICATION	Sequentially list condition if any, leading to immedia	s, b					1 77	regi					
S	cause. Enter UNDERLYING CAUSE (Disease or Injury		Lux	OF AS A CONS	1016	25							
쁜	that initiated events resulting in death) LAST				EQUENCE O	F):							
1 1 1	rooting in south, crop	d	(0	PD									
	PART II. Other significant	conditions o	contributing to	death but not	resulting	In the ur	derlyln	g ceuse (given in F		AN AUTOPSY		WERE AUTOPSY FINDINGS
EDICAL											2 DO NO		MAILABLE PRIOR TO COMPLETION OF CAUSE
							_			_	1		OF DEATH?
N.													
N N	25. WAS CASE REFERRED TO M							ACE OF D	EATH (Che	ck only one)			
SIG	1 TES 2 NO	1	OSPITAL:	ER/Outpatient	3 🗆 DOA	4 Nur		e 5 □ Re	sidence (Other (Specify)			
PHYSICIAN	27. MANNER OF DEATH		28a. DATE OF (Month, D		26b. TIN	IE OF JURY	28c. INJ WO	URY AT		28d. DESCRIBE HO	V INJURY O	CCURED	
₽	1 Netural 5 Per 2 Accident Inve	estigation				М		YES 2	NO				
		aid not be	26e. PLACE O building,	F INJURY — At h etc. (Specify)	ome, farm,	street, faci	lory, offic	•		261. LOCATION (Stre City or Town, Str		er or Rural Ro	ute Number,
⊢													
절										to the cause(a) and i			
COMPLE	2 MEDICA	- //	the basis of a	xamination and/or	investigation	on, in my c	pinion, d	eath occur	red at the t	ime, deta and placa,	and due to	the cause(s)	and menner as stated,
BE	296 SIGNATURE AND TITLE OF	CERTIFIER	D	()	λ	۸)		29c. LICE	NSE NUM	BER	29d. DA	TE SIGNED	Month, Day, Year)
2	30-MAME AND ADDRESS OF PE	W.	OMBI EXEC	D. P.	D,	2		7	560	18	3	113/	7.5
	CTELIKA? [LA LO	200 0	SE OF DEATH ITT	ем 27) (Туре Анаг	ST	A	NN	LAO	Li or	1	211	101
	31 DATE FILED (Month, Day, Year	1 01 4		AR'S SIGNATURE	1-5	111	* V	1 - 4-	T	13/	D	(/ (0/
	MAR 19	93	Lulio.	Said	D	10							
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MARYLAND 21215-0	between the state beautiful or the other of the state
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1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

ROSSITER

5. SEX

CLAIRE

4. SOCIAL SECURITY NUMBER

DIVISION OF VITAL RECORDS DO BOX 68760

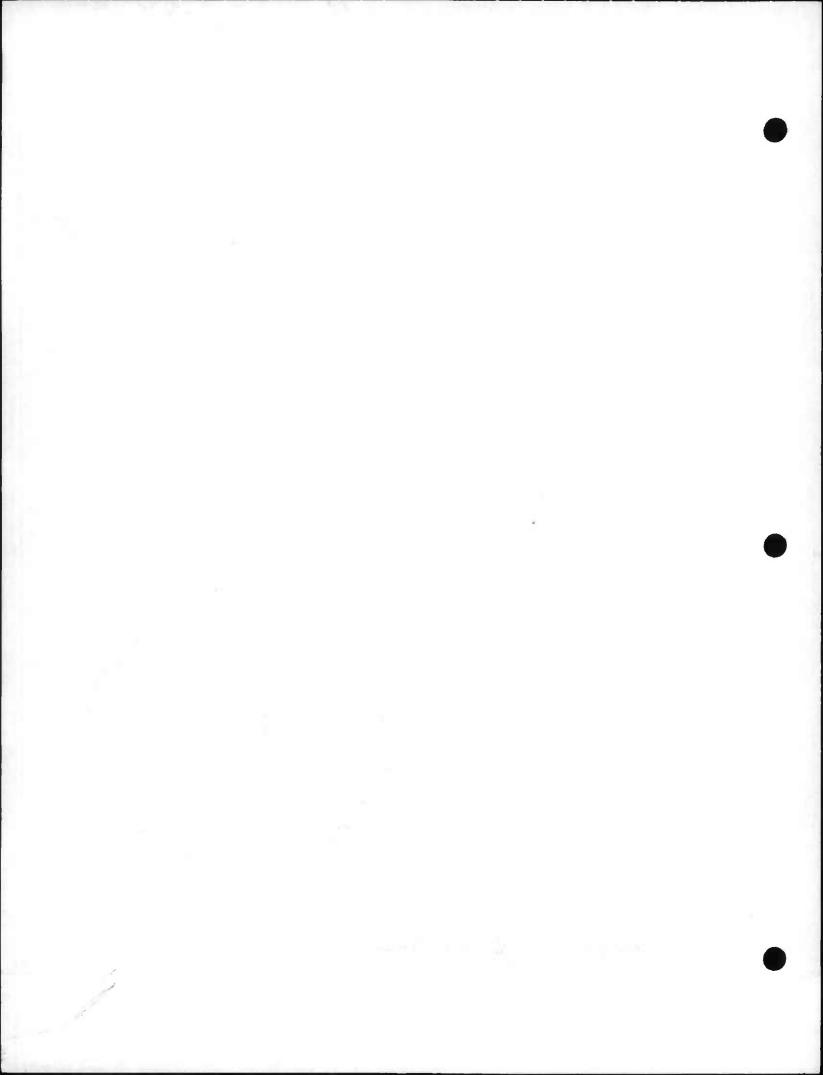
		209-26-166	9	1 □ M 2 🂢 F	59	YRS.	MONTHS	DAYS	HOURS	MIN.	04 /	03/1
should	1	8a, FACILITY NAME (If not in	stitution, give :	street and number)			96. CIT	, TOWN	OR LOCATI	ON OF DEA		
6,	DIRECTOR	PRINCE GEOF	RGE S	HOSPITAL C	ENTER		CHE	VERL	Y.			
9068	E	10a. STATE	10b. COUNT	Y		10c. CIT	Y, TOWN	OR LOCA	TION			
permit. Pages 1,		Maryland	Princ	e George's	5	Ri	verd	dale				
it per	FUNERAL	10s. STREET AND NUMBER							. ZIP COD	-		
physician. burial-transit	R	6321 67th	Court	12 WAS DECEDENT	VED IN H C AD	MED	10	_		7-173		AD 14 14
2 2 2	BY	11. MARITAL STATUS 1 Never Married 2 X Married 2 X Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO If yes, specify Cuban, Mexican, Puer 1 Yes 2 XNO Specify:										
	ETED		EDENT'S EDU highest grade		(G	ive kind of	USUAL O		ON ost of working	ng	16b. I	KIND OF B
oital or of for u	12	Elementary/Secondary (0	-12)	College (1-4 or 5+)		Do NOT u						
the hospital detached for	COMPL	17. FATHER'S NAME (First, M	iddle, Last)		П	ouse	wire		18 MOT	HER'S NAM)wn
\$ & &	Ü	George We								omi		
retained to should notified	00	19a. INFORMANT'S NAME (7			198	b. MAILING	ADDRES	\$ (Street a		or Rural Ad		
	2	Ferdinand	Rossi	ter	6	321	67th	Cot	ırt,	Rive	rdale	, Ma
6 may be ector, page		20a. METHOD OF DISPOSITI	ON n 3 □ Rem	oval from Stata	20b. PLACE	AND DATE	OF DISPOS	SITION (N	ame of		OATE	20c. L
Page 6		4 ☐ Donation 5 ☐ Other 21. SIGNATURE OF FUNERA	(Specify)		Metro	polit				y 3/1		AI
death. Page 6 may be funeral director, page 1.		21. SIGNATURE OF FUNERA	, On	I A M	2/					ss of FAC		ons
0 = 0		the	Wes -	Beg	1	-	4	739	Balt	imore	e Av	enue
ed in		23. PART i. Enter the di shock, or he	seases, or ert failure.	complications that c List only one ceuse	aused the de on each line	ath. Do	not anter	tha mo	de of dy	ing, such	aa cardi	ec or rea
fille on,		iMMEDIATE CAUSE (Findisease or condition	ei		1 -				1			
ted within 24 I completely fille ial, cremation,		resulting in death)	→	a. DUE TO (O	R AS A CONSE	DUENCE O	a	m	N.	7	-	
A 5- 9	_			· ma	dine	P	enel		0 .	land	n. 1	
o exection and to be	CATION	Sequentially list conditi if any, leading to immediate		DUE TO (O	R AS A CONSE	UENCE O	F);				1	an
the death certificate be executed the attending physician and code Mental Hygiene prior to burial Injury, or other traumatic	S	cause. Enter UNDERLYi CAUSE (Disease or inju		a arut	e H	on	tic		Sus	seel	in	<u> </u>
certificate ding physi lygiene pri	TE	that initiated events resulting in death) LAS		DUE TO (O	R AS A CONSEC	DUENCE O	F):					
te death certificate attending phy Mental Hygiene ljury, or other	CERTIFI	A A A A A A A A A A A A A A A A A A A	_	d								
at the day the and Me		PART II. Other significa	nt condition	s contributing to de	eth but not r	esuiting	in the u	nderlyin	g cause (given in P	art i.	24a. WAS A PERFO
9 5 5 6	MEDICAL										_	1 TYES
law requires the same speed signed speed signed sept. of Health 23 shows or	ME										_	
law ras be Dept.	CIAN:	25. WAS CASE REFERRED TO										
AN: The law re lifticate has bee 5 State Dept. o	SICI	EXAMINER?	MEDICAL	HOSPITAL:			OTHE	R:		EATH (Chec		
SICIAN certifi certifi the	PHYS	27. MANNER OF DEATH	-	1/ Inpetient 2 = E	JURY	28b. TIN		sing Horr 28c. INJ		sidence 6		(Specify)
IDING PHYSICIAL After this certificate death with the smerked, or	ву Р		Pending nvestigation	(Month, Day,	Year)	IN.	JURY	WC	YES 2		•	
ATTENDING PHYSICI. CIT.R.: After this cert death with the		3 Suicide 6	Could not be	28e. PLACE OF I building, etc	NJURY — At ho	me, farm,	street, fac	tory, offic			281. LOCAT	TION (Street
E HE HE	COMPLETED	4 Homicide	determined		.,,,						Oily G	nown, otal
2 2 2	IPL		FYING PHYS	ICIAN: To the best of my	knowledge, de	ath occurr	ed at the	lima, data	and place	, and due t	o the caus	e(a) and m
(E3)E	NO.	one) MEDI	CAL EXAMINE	R: On the basis of axen	nination and/or i	investigation	on, in my o	opinion, d	leath occu	red at the ti	me, date a	nd place, a
m m 2 K	BE C	36. BIGHNTURE AND TITLE	OF CENTIFIE	· ·					Z9E LICI	ENSE NUMB	IER -	
TO THE HISPIT TO	0	+ Pulan	4	to un	9				Do	106	23	
2		30. NAME AND ADDRESS OF	REASON WH	O COMPLETED CAUSE	OF DEATH OTES	W 27) (Type	Printi					
(0		31. DATE FILED / Mongo, Day.	bari	32. REGISTRAD'S	SIGNATURE	-	_					
		MAR O	8 199	3 gener	Devidoon-	Mando	22					

CERTIFICATE OF DEATH

6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

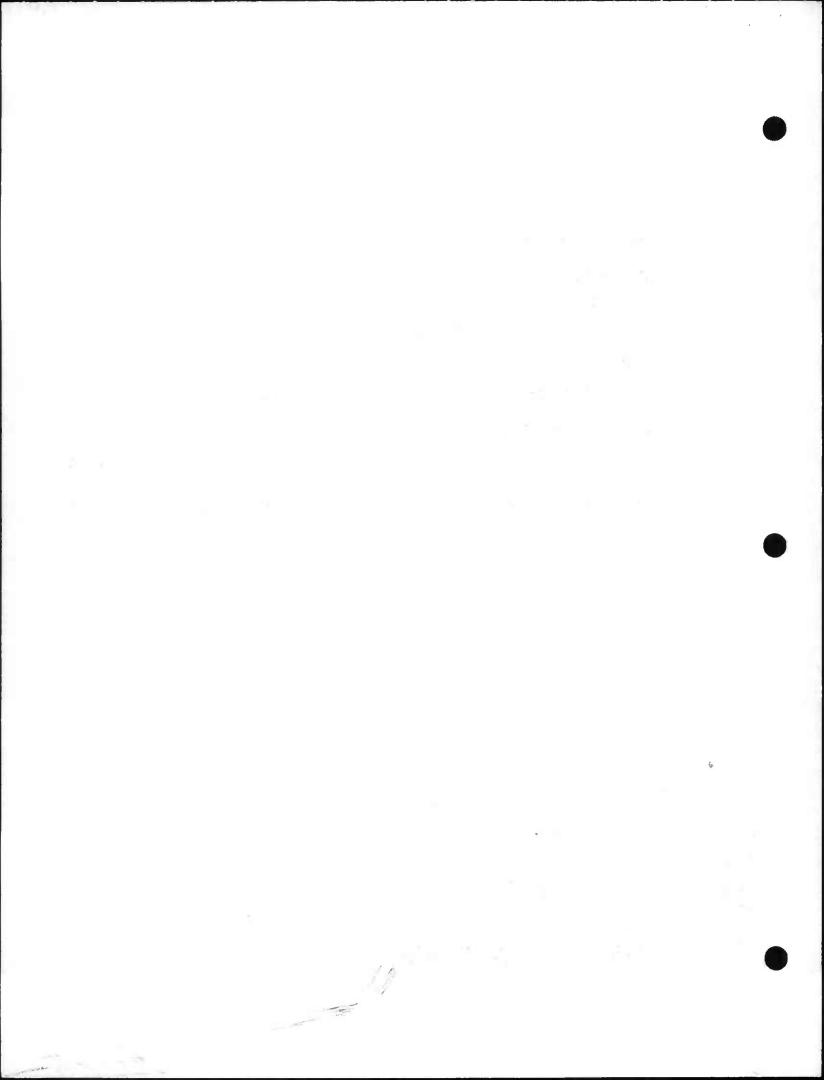
MARCH

08923 93 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 2. DATE OF DEATH 3. TIME OF DEATH 1993 04 12:45 7. DATE OF BIRTH (Month, Day, Year) 04/03/1933 B. BIRTHPLACE (State or Foreign Philadelphia, PA 9c. COUNTY OF DEATH PRINCE GEORGE'S 10d. INSIDE CITY 1 - YES 2 X NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE - American Indian, Black, White, atc. White USINESS/INDUSTRY Home n Surname) wn, State, Zip Code) aryland 20737-1732 OCATION — City or Town, State exandria, Virginia Funeral Home, P.A. Hyattsville, MD Approximate interval Between piratory arreat, Onset and Death acceles 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? N AUTOPSY 1 YES 2 NO INJURY OCCUREO t and Number or Rural Route Number, anner as stated. and due to the cause(s) and manner as stated,



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	REGISTRAR 1. DECEDENT'S NAME (First,	, Middle, Last)			CERTIF	ICATE O	F DEATH	2. DATE OF DE	G. NO.	3	. TIME OF DE	ATH
	Milton Foster Robinson Sr. March 2, 1993 YEAR 07											A
	4. SOCIAL SECURITY NUMBER 247-38-9125	BER	5. SEX	6. AGE (In)	yrs. lest birthday)	IF UNDER 1 YEAR		7. DATE OF BH (Month, Day, Oct 13	RTH Year)	8. BIRTHPL Country)	ACE (State or	Foreign
	80. FACILITY NAME (If not in	astitution, give s			65 YRS.	9b. CITY, TOW	N OR LOCATION OF D			EASLE NTY OF OEA	TY, S.	<u> </u>
OR	Malcolm Grov		Medical	Cent	er		vs AFB, M			ce Ge		
DIRECTOR	RESIDENCE OF DEC	10b. COUNT	Υ		10c. CIT	Y, TOWN OR LO	CATION				Dd. INSIDE CI	γ
	MARYLAND	PRIN	CE GEORGE	E'S		LANDOVE	R			1	VES 2] NO
ERAL	100. STREET AND NUMBER 8000 ALLE	ENDALE.	DRIVE				101. ZIP CODE 20785			ZEN OF WHA	AT COUNTRY	
FUN	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.	S. ARMED	13. WAS 0	ECENDENT OF HISPA	NIC ORIGIN? (Spe	ecify Yea or No —	14. RACE -	- American in	lien,
BY	1 Never Married 2 XXX 3 Widowed 4 Divo		6/29/45	12/8/	2 NO NAVY If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 & YES 2 NO Specify: Specify:						11127-022	
ED		EDENT'S EQU	CATION -55	55 to	SO. DECEDENT'S	USUAL OCCUPA work done during	TION	16b. KIND	OF BUSINESS/IND		BLACK	
LET	Elementary/Secondary (0		College (1-4 or 5	+)	Illu. Do NOT us	se retired.) TER/ CH			PVT.			
COMPL	17. FATHER'S NAME (First, Mi		4YRS.			111117 (71		AME (First, Middle,				_
BE C	MARSHALL		SON				IDA	MAE Mo	QUIRKER			
TO	MRS. DORI		ROBINSON	V			ALE DR. I					
	20s. METHOD OF DISPOSITION 1 Burlat 2 To Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCAT										, State	_
	4 Donation 5 Other	(Specify)		Cl	HAVBERS				RIVERDA		ÄRYLAN	D
	11/Out	10 11 0	RIA	1/4	1		E. JENKII					
	23. PART I. Enter the di	leeses, or	complications tha	Caused II	ne daeth. Do r		74 LANDOVI					
	shock, or he IMMEDIATE CAUSE (Fin	eart failure.	List only one cau	ise on sech	iine.	or ornar trio	noda or dying, sur	JI as Cardiac C	n respiratory air	est,	Approxii intervai Onset a	Bet
	disease or condition resulting in death) Chronic Obstructive Pulmonary Disease Due TO (OR AS A CONSEQUENCE OF):											
7			DUE TO	(OR AS A CO	ONSEQUENCE O	F):						
CATION	Sequentially list conditi if any, leading to immed	diate	DUE TO	(OR AS A CO	ONSEQUENCE OF	F):						
FIC	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFI	resulting in desth) LAS	, (d									
	PART II. Other algorifice	nt condition	s contributing to	death but	not resulting	in the underly	ing cause given in		WAS AN AUTOPSY		ERE AUTOPSY	
EDICAL									PERFORMEO?	CC	MILABLE PRIO DMPLETION OF F DEATN?	
Σ								_			☐ YES 2X	NO
PHYSICIAN:	25. WAS CASE REFERRED TO) MEDICAL				26.	PLACE OF DEATH (C)	neck only one)				-
YSIC	1 YES 2 NO		HØSPITAL: 1 ☐ Inpetient 2	ER/Outpatia	ent 3 🗆 DOA	OTHER:	ome 5 - Residence		city)			
		Pending	28e. DATE OF (Month, D		28b. TIM	URY	NJURY AT WORK?	28d. DESCRIBE	HOW INJURY OCC	URED		
р Вү	2 Dutelde	investigation Could not be	28e. PLACE O	F INJURY — etc. (Specify)	At home, farm, i	street, factory, of	YES 2 NO	28f. LOCATION	(Street and Number	or Rural Rout	e Number,	
ETED	4 Homicide	determined	Delivery,	orc. (Specify)				City or Town	n, State)			
COMPL							ite end place, end du					
	290. SIGNATURE AND TITLE	_		Carpination ar	id/or investigano	n, in my opinion	, death occured at the					_
	29c. LICENSE NUMBER 29d. DATE SIGNED (Month). March 2,											
38 0	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS	SE OF DEATH	(ITEM 27) (Type,				dical Ce	nter	,	
TO BE	T de red T7 / 10				MC	Andr	OTTC ATR	WD 3033	1_5200			
	Edwin K. Bur	8 199	Captain,	R'S SHIMATH			ews AFB,	ты 2000	1-3300			_



TO THE MISPITAL DISPITATIONIS PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.

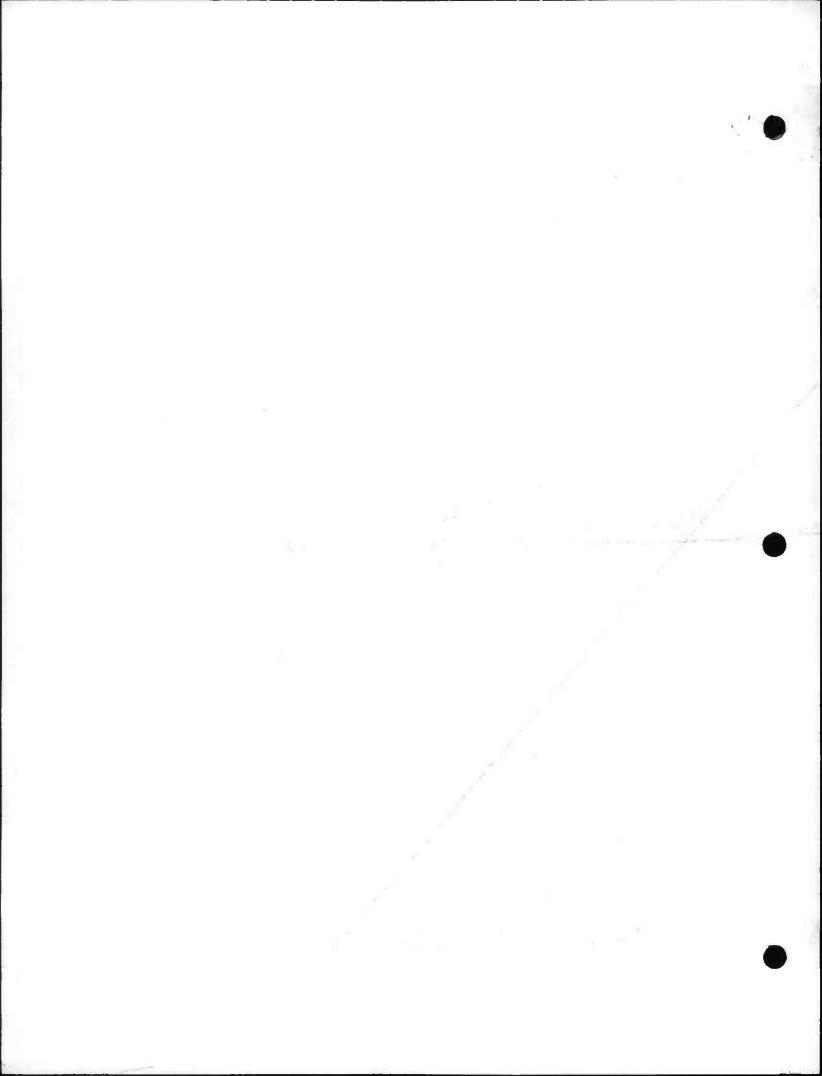
TO THE PUREAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 28 after death with the State Dept. of Meath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAN				ENTIF	ICATE	. OF	DEA	Ш		REG. NO.			
	1. DECEDENT'S NAME (First		220							2. DATE OF MONTH	DEATH DA	IA.	YEAR	3. TIME OF DEATH
	SADI		M.	RUDD								, 19	93	1:10 p M
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. le	ast birthday)	IF UNDER		IF UNDER		7. DATE OF	BIRTH		8. BIRTI- Count	HPLACE (State or Foreign
1 1	022-66-9750)	1 🗌 M 2 💢 F	74	YRS.	MONTHS	DAYS	HOURS	ms Min. (Month, Day, Year)			918	Mas	sachusetts
	9a. FACILITY NAME (If not in	stitution, give s	street and number)			96. CITY,	TOWN (OR LOCATE	ON OF DE				NTY OF D	DEATH
8	Doctors Co	ommuni	tv Hospi	ta1		1	anh	am				Pri	nce	George's
5	Doctors Co				_									000.80
DIRECTOR	Maryland	10b. COUNT	r ce George	1.	10.10	Y, TOWN O								10d. INSIDE CITY LIMITS?
	_	PLIN	de George	S S	H	yatts					XX YES 2 □ NO			
FUNERAL	100. STREET AND NUMBER 4911 78th A	venue			101. ZIP CODE 20784						10g. CIT	U.S.	what country? .A.	
5	11. MARITAL STATUS	-W	12. WAS DECEDEN	T EVER IN U.S. A	AMED	13, 1	WAS DEC	ENDENT O	F HISPAN	VIC ORIGIN? (S	pecify Yes	or No-	14. RACI	E — American Indian, k, White, etc.
B	1 Never Married 2 3 3 Wildowed 4 Divo		IF YES, GIVE V		į vo	i	YES	2XXN0	Specify	m, Puerto Rica y:	n, euc.)		Speci	
COMPLETED		EDENT'S EDU		16a, D	ECEDENT'S	USUAL OC	CUPATK	ON				HNESS/INI		
	Elementary/Secondary (0		College (1-4 or 5	F) ##	Give kind of e. Do NOT u	se retired.)	111.		g					County
<u>=</u>	12			Sc	hool	Secr	eta:	ry		Boa	rd o	f Edu	ucati	ion
ő	17. FATHER'S NAME (First, M							18. MOTI	HER'S NA	ME (First, Midd	le, Maiden	Surname)		
BE (Michael J.	-						Sar	cah 1	Murphy				10
0	19a. INFORMANT'S NAME (7									Route Number,				
=	Sandra Lee	Midgle	БÀ	8	406 1	/lagno	lia	Driv	re, I	Lanham	, Mai	rylaı	nd a	20706
	20a. METHOD OF DISPOSIT		corel from State	20b. PLACE	AND DATE	OF DISPOSI	TION /Na	ame of		DATE	20c. LO	CATION —	City or To	own, State
	4 Donation 6 Other	(Specify)		Fort	Line				·	9-93				Maryland
1 1	21. SKONATURE OF FUNE AL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY RENCON/Hale Lanham Funeral Home													
	9013 Annapolis Rd., Lanham, Maryland 2070											and 20706		
\Box	23. PART I. Errer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximat											Approximate		
mock, or neart failure. List only one cause on each line.											interval Between Onset and Death			
iMMEDIATE CAUSE (Final disease or condition resulting in death) a. Certain Attack the consequence of):											Onset and Death			
	resulting in death)		DUE TO	(OR AS A CONSE	QUENCE O	Fi:	0	117	10	90				
-						,				1				j
CERTIFICATION	Sequentially list conditi if any, leading to imme-		DUE TO	(OR AS A CONSE	QUENCE O	F):								
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	cause. Enter UNDERLY	ING												!
Ē	CAUSE (Disease or inju that initiated events		DUE TO	(OR AS A CONSE	QUENCE O	F):								
ᇤ	resulting in death) LAS	T	d											
	PART II. Other algnifica	nt condition	ne contributing to	dooth but not		In the con	4 - 4 - 4 - 1			D 41 14				
EDICAL	Air ii. Other aigninea	CONCINIO	a contributing to	death but not	resulting	in the un	geriying	g cause ç	jiven in	Part I. 24	PERFOR		24b	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
ă										1	YES 2	NO		COMPLETION OF CAUSE OF DEATH?
Σ										_				1 TES 2 NO
N N														
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HQSPITAL:			OTHER		ACE OF D	EATH (Ch	eck only one)				
ΥS	1 YES ZXNO			ER/Outpatient			_		sidence	6 Other (S)				
표	_	Pending	28a. DATE OF (Month, D		28b. TIM	JURY		RK?		28d. DESCRI	BE HOW II	NURY OC	CURED	
n 2 Accident Investigation " 1 YES 2 NO] NO						
3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, offics building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, offics City or Town, State)									or Rural F	Route Number,				
U CONTINUE C											_			
COMPLET		IFYING PHYS	ICIAN: To the best of	my knowledge, d	eath occurr	ed at the ti	me, date	and place,	and due	to the cause(:) and man	ner se sta	ted.	
0	one) 2 MEDI	CAL EXAMINE	R: On the besis of s	xamination snd/or	Investigation	on, in my o	olnion, d	leath occur	ed at the	time, dats and	place, sn	d due to ti	10 CBUSO(E	s) and menner as stated.
1 1	296. SIGNATURE AND TITLE	OF CERTIFIE	A					29c. LICE	NSE NUN	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
) BE	Pech) BC.	D	201	a			D	925	7		•	216	193
임	30. NAME AND ADDRESS OF	PERSON WH											11/2	11)
	Robert Ge	reice	e. M.D.	4410	74+	h 2 17	P	Land	in F	ar Ui	110	M		nd 20784
	31. DATE FILEM AND DE	80199	32. REGISTRA	R'S SIGNATURE	Aanda	02	~	пан	70 V 6		115	mar	ATGI	14 24/84
1		2	' "	Annual Configuration										



FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Midd	olo, Last)	./	L.	R	20					2. DATE	OF DEATH	AY	YEAR 3.	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		SEX		in yrs. last t	birthday)	IF UNDER 1	YEAR	IF UNDER	24 HRS.	7. DATE C	OF BIRTH	- 4	3 D	CF (State & Foreign
8	216-58-5518 9a. FACILITY NAME (If not institution		M 2 F	40	_	YRS.	IONTHS	DAYS	HOURS	MIN.	05 ^(Month)	O1	52	Mai	yland
2	PRINCE GEORGE	E'S HO							or Location	ON OF DE	HTA		Princ	ry of deat e Geo	
Dinection		COUNTY	Georg	0		10c. CITY, TOWN OR LOCATION 10d. Riverdale							d. INSIDE CITY LIMITS?		
- 1	10e. STREET AND NUMBER					R	Tver		LE 1. ZIP CODE				10g. CITIZ		TOUNTRY?
	6207 54th									0773				USA	
	1 Never Merried 2 Merri 3 Widowed 4 Divorced	fed .	WAS DECEDED FORCES? IF YES, GIVE	NT EVER IN I YES WAR OR DA	2. 240 TES	ED	16	yes, sp	DENDENT OF CUbe S 2 NO		n, Puerto R	? (Specify Yer licen, etc.)	s or No	Black, W Specify:	American Indian, hite, atc. White
בובה	15. DECEDEN (Specify only high Elementary/Secondary (0-12)	1	oleted)		(Give	EDENT'S US kind of wor	rk done du		ON ost of workin	9	16b.	KIND OF BU	SINESS/INDU	STRY	
	9th		ollege (1-4 or 5	+)		Mair	nten	ano	e Eng	jine	er	P	rivat	е	
	17. FATHER'S NAME (First, Middle,	Cla	ude	R	Reed					larga		liddle, Maiden		hapma	~
	194. INFORMANT'S NAME (Type/P) James E.	Print) Reed	7						and Number	or Rural F	loute Numb		n, State, Zip (11
	204-METHOD OF DISPOSITION			20ь.		DDATE OF				erda	ale,	Md 20	773 CATION C	ify or Town,	State
	1 Burial 2 Scemation 3 4 Donation 5 Other (Spec	clfy)		ceme	etery, cremi	atory or othe	mori	al	Park		/93	-			yland
21. SIGNATURE OF FENERAL GERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 3. B. Jenkins Funeral Home 7474 Landover Rd/Landover, Md 2078 23. PANY 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												705			
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING			O (OR AS A				_			7				
	CAUSE (Disease or Injury that initiated events resulting in death) LAST	d	DUE TO	(OR AS A	CONSEOU	ENCE OF):									
	PART II. Other significent co	onditions co	entributing to	deeth bu	ut not res	sulting in	the und	erlyin	g cause ç	iven in	Part I.	24a. WAS AN PERFOI 1 TYES 2	RMED?	AM CC OF	IRE AUTOPSY FINDING ALABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
	25. WAS CASE DEFERRED TO ME	DICAL						26. PI	LACE OF D	EATH (Che	ock only one))			
THI SICION.	EXAMINER?		SPITAL:	☐ ER/Outpo	atient 3		OTHER:		ne 5 🗆 Re	sidence	6 🗆 Other	(Specify)			
10	27. MANNER OF DEATH 1 Netural 5 Pendi	ling digation	28e. DATE Of (Month, I			286. TIME (WO	JURY AT ORK? YES 2	NO	28d. DE\$	CRIBE HOW	NJURY OCCL	JRED	
		At home, farm, street, factory, office 281, LOCATION (Street and Number or Rural Route Number													
3	3 Suicide 8 Could		28e. PLACE (building	OF INJURY , etc. (Speci	— At home	e, ferm, str	eet, factor	y, offic	e e					r Rural Rout	Number,
	3 Suicide 8 Could 4 Homicide 8 Could detern 29a. CERTIFIER (Check only	d not be mined	: To the best o	, etc. (Speci	edge, deat	h occurred	at the tin	ne, date	end place,		City of	er Town, Stete,	nner ee state	d.	
DE COMM ELIED	3 Suicide 8 Could 4 Homicide 8 Could detern 29a. CERTIFIER (Check only	d not be mined	: To the best o	, etc. (Speci	edge, deat	h occurred	at the tin	ne, date	end place,	ed at the	to the caustime, date	se(s) end me	nner ee state	d. cause(e) er	d menner as stated.
۱ د	3 Suicide 8 Could 4 Homicide 8 Could detern 29a. CERTIFIER (Check only one) 1 CERTIFYIN 2 MEDICAL	d not be mined	: To the best of	, etc. (Speci	edge, deat	h occurred	at the tin	ne, date	end place,	ed at the	to the caustime, date	se(s) end me	nner ee state	d. cause(e) er	d menner as stated.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

the hos	detach	once.
The Indian Mark Mark Mark Interest of the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	Numbles certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach ream with the State Dept, of Health and Mental Hydiene prior to burial, cremation, or removal	IMPORTANT. If ite 23, consider, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ay be	page	e e
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death.	e fune	ехаш
after	by th	Cal
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d with	TO THE PLACE AND THE COMPANIES CENTIFICATE has been signed by the attending physician and completely filled in by the funer be filed within 72 numbers and completely filled in by the funer be filed within 72 numbers and the filed within the State Dect, of Health and Mental Hydiene prior to build. cremation, or removal	event
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De e	cian a	raum
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TO THE HOSPITAL	TH OTH	MPO
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

											93	3 (08927
FOR STATE REGISTRAR		STATE OF N	IARYLAND	/ DEPAR	RTMENT	OF H	EALTH	AND			Ε		
1. DECEDENT'S NAME (First	, Middle, Last)				TOATE	. 01	DLA	-	2. DATE OF	REG. NO.			
RI	CHARD	REDL	TN 1	RAIHI	.E				MONTH	DA		YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUM		5. SEX	8. AGE (In yrs.						Marc		8 13	993	7:45 pm M
399-26-	3555	K [X M 2 ☐ F	70	YRS.	MONTHS	DAYS	HOURS	MIN.	7. DATE OF (Month, D		222	Count	HPLACE (State or Foreign try) SCONSIN
9a. FACILITY NAME (If not is	nstitution, give s	treet and number)			9b. CITY,	TOWN C	OR LOCATION	ON OF D				JNTY OF D	
Mallard	Bay	Nursing	Home			(Camb	rid	2 e		Dor	che	ster
RESIDENCE OF DEC									0 -				0001
10a. STATE	10b. COUNTY			10c, CIT	TY, TOWN O	R LOCAT	ION						10d. INSIDE CITY
va. rairiax fairfax									LIMITS? 1X XYES 2 NO				
10e. STREET AND NUMBER						101	ZIP CODE	E			10g. CIT	IZEN OF	WHAT COUNTRY?
5340 Jennifer Drive 22032 U.S.A.									S.A.				
11. MARITAL STATUS 1 Never Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X MO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No— FORCES? 1 YES 2 X MO 14. RACE — American Black, White, atc.													
IF YES, GIVE WAR OR DATES YES 20 TUNO Souther 1										white			
1 1943-1904													
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT see retired.) 16b. KIND OF BUSINESS/INOUSTRY													
Elementary/Secondary (0	12)	College (1-4 or 5 +) '		,								
17. FATHER'S NAME (First, M		5 +		Mari	пе в	ngı				U. S		avy	
	,	laihle					18. MOTH	IER'S NA	ME (First, Midd				
19a, INFORMANT'S NAME (1		ainie								thea			1
		1							Poute Number,				
Mrs. Irene		Te		5340	Jen	nif	er l	Driv	ve, F	airf	ax	VA.	22032
20a. METHOD OF DISPOSIT 1 □ Burial 2X□XCrematic	n 3 🗆 Remo	oval from State	20b. PLAC	EAND DATE	OF DISPOSIT	TION (Ne	me of		OATE	20c. LO	CATION -	City or To	wn, State
4 Donation 5 Other			Sal	isbu:	ry C	rem	ato	ry 3	3/19	Sa	lis	bury	Md.
21. SIGNATURE OF FUNERA					22. N	IAME AN	D ADDRES	S OF FA	CILITY				
> Kenne			11		Th.	O L oma	ocus s Fi	st S iner	St. C.	ambr ome	idg	e Md	1. 21613
23. PART I. Enter the di shock, or h	seeses, or c	omplications that list only one caus	ceused the	leeth. Do r	not enter t	the mod	de of dyl	ng, aucl	h es cardiec	or respir	atory an	rest,	Approximete
IMMEDIATE CAUSE (Fir	el												Interval Between Onset end Death
disease or condition	→	Sens	1										11 -1
resulting in death)	· ·	DUE TO	OR AS A CONS	EOUENCE O	f):								Vecks
	disease or condition resulting in death) a. Septe f DUE TO (OR AS A CONSEQUENCE OF):												
Sequentielly list conditi													
cause. Enter UNDERLYI	NG												i l
CAUSE (Disease or Inju that initiated events	Ly C	OUE TO (OR AS A CONS	EQUENCE OF	F):								
resulting in deeth) LAS	T :												
d.													

RT II. Other significent condition	contributing to death but not resulting in the underlying ceuse given in Pa	ırt
	tature state	
Mronic Dela	terms I fair	

24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO extrovascular Accident

24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	1 TYES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO

27. MANNER OF DEATH

1 Natural 2 Accident

3 Suicide

HOSPITAL:
1. | Inpetient 2 | ER/Outpetient 3 | DOA 26a. DATE OF INJURY (Month, Day, Year)

g Home 5 - Residence 8 - Other (Spec	_		-	~~	01	DEATH (CI	MUN U	thy one	"
	g	Но	me	5		Residenca	8 🗆	Other	(Specify

26b. TIME OF

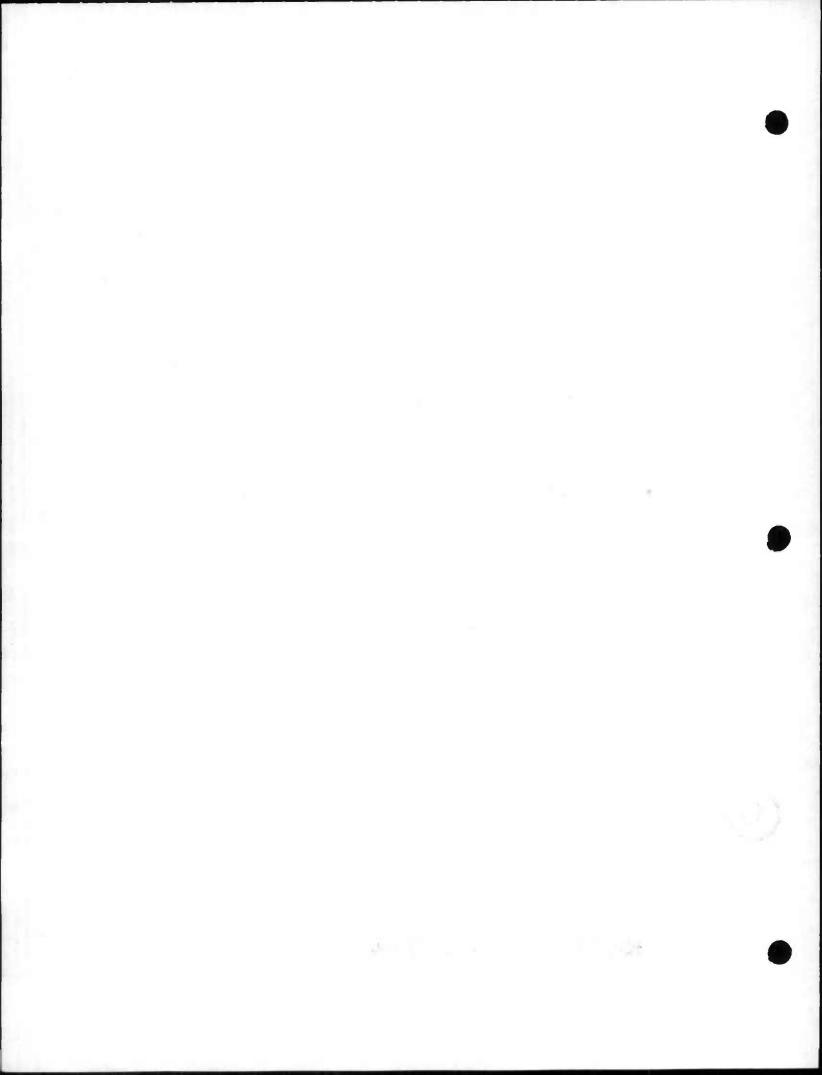
WORK? 1 YES 2 NO	and Describe HOW INSURT OCCURED	
ory, office	281, LOCATION (Street and Number or Rural Route Number,	

28e. PLACE OF INJURY — At home, farm, street, fact building, etc. (Specify) 8 Could not be determined 4 Homicide

	 or investigation, in my opinion,	oeath occured at the lime, dat	a and place, and de	us to the cause(s) and manner as state
CHARGEST AND TOTAL OF COMMERCES				
CHARGE AND TITLE OF CENTIFIER		29c. LICENSE NUMBER	29	ed. DATE SIGNED (Month Day Year)

32. REGISTRAR'S SIGNATURE

MAR. ² 2 2 2 3 3

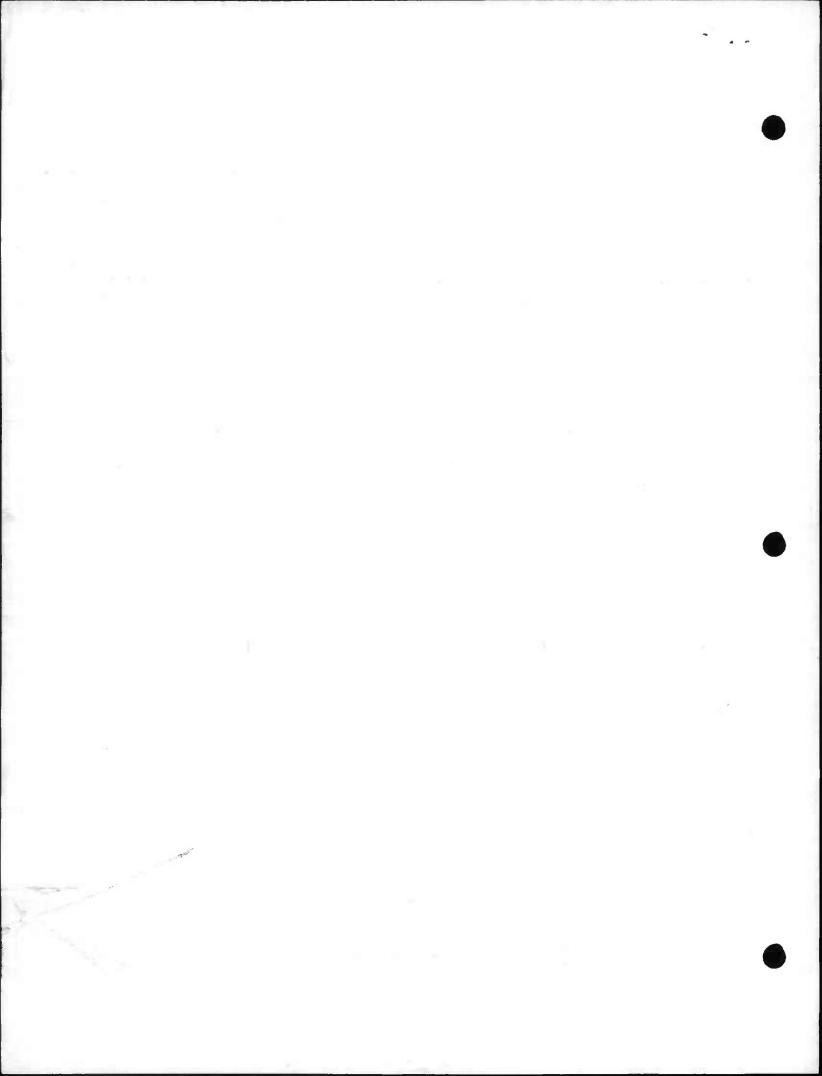


TOTAL US ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO HIGH AND SHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be attended after that his contribution of the situation of the

MAR 1 8 '93

	1 - FOR STATE REGISTRAR		STATE OF I			TMENT			MENTAL HYGIEN	E 3 3	Uč)) 2 0		
	1. DECEDENT & NAME (First,	Middle, Lest)	Raphas	el K	1.	Red	ed:	n	2. DATE OF DEATH MONTH DA		YEAR 93	3. TIME OF DEATH		
	4. SOCIAL SECURITY HUM	ER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER 1		UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTHP	LACE (State or Foreign		
	186-26-8298		1 2 M 2 F	64	YRS.	MONTHS		OURS MIN.	Nov. 23, 1	Country)				
	9a. FACILITY NAME (If not in		reet and number)	0		9b. CITY, T	TOWN OR L	OCATION OF DE		1928 Gettysburg, P.				
ECTOR	University	tal				re City		00 115	timo					
B	10a. STATE		10c, CIT	Y, TOWN OR	LOCATION			-	1	IOd. INSIDE CITY				
DIR	PA	ork		anove	r					LIMITS?				
FUNERAL	10s. STREET AND NUMBER						10f. ZII	P CODE		10g. CITE	ZEN OF WH	IAT COUNTRY?		
單	6 Oak Stre	et						1733	1	υ.	S.A.			
5	11. MARITAL STATUS			T EVER IN U.S. AR		13. W	AS DECENE	DENT OF HISPAN	HC ORIGIN? (Specify Yes	or No-	14. RACE -	- American Indian,		
	1 Never Married 2 🔀	111	IF YES, GIVE V	YES 2 X N	10			y Cuban, Mexica NO Specifi	n, Puerto Rican, etc.)		Specify:	White, etc.		
В	3 Widowed 4 Divo	rced									Whit			
	15. DEC	EDENT'S EDUC	CATION			USUAL OCC		4	16b. KIND OF BUS	SINESS/IND				
<u> </u>	Elementary/Secondary (0		College (1-4 or 5	Elia .	Do NOT us	e retired.)	ring most of	wonung	ŀ					
를			1		Sale	esman			Medic	al St	ippli	es		
COMPLETED	17. FATHER'S NAME (First, M	liddle, Last)					16	. MOTHER'S NA	ME (First, Middle, Maiden	Surname)				
BE C	Allen Ste		Redding						ne Unknown					
5	Jacqueline	L. Re	dding					Hanove:	Route Number, City or Town	n, Stata, Zip 331	Code)			
	20a, METHOD OF DISPOSITI 1 ☑ Burlel 2 ☐ Crematic 4 ☐ Donatien 5 ☐ Other	on 3 🗆 Remo	oval from State	20b. PLACE A cametery, cre- St. Vir	matory or of	ther place)		of	3/17/93 Ha		City or Town	n, State		
	Bryan	W. Cla	·cear	4)	22. NA	AME AND A	On-Mite	chell-Wiede	feld	Inc			
	23. PART I. Enter the di		-	to and the de	oth Day		OW.	Pador	nia Road,	timor	nium,			
	shock, or he IMMEDIATE CAUSE (Fin disease or condition resulting in death)	eart feilure. L	Liet only one cau	se on each line) lus	~2	ne mode	or aying, suci	n as cardiac or respi	ratory arr	eat,	Approximate Interval Between Onset and Death		
NO	Sequentially list conditi	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING Sus tayned Canadiae Arrest DUE TO (OR AS A CONSEQUENCE OF): Sus tayned Canadiae Arrest												
		ione						1-00	and and and					
CATIC	if any, leading to immer cause. Enter UNDERLY!	diate ING	Sus 8	(OR AS A CONSEC	DUENCE\DF	Para	liac	Ar	rest					
ERTIFICATION		diate ING Iry c	Susy	OR AS A CONSEC			liae	Ar	rest					
L CERTIFICATION	cause. Enter UNDERLY! CAUSE (Disease or injuthat initiated events resulting in death) LAS	diate ING ary	Sus 8 DUE TO	COR AS A CONSECUTION	DUENCE OF	7:		A r		ALTTOREY	245	WITE AUTORS FEMALUS		
EDICAL	cause. Enter UNDERLY! CAUSE (Disease or Inju that initiated events	diate ING ary	Sus 8 DUE TO	COR AS A CONSECUTION	DUENCE OF	7:		A parameter and the state of th		AUTOPSY	0	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO		
MEDICAL	cause. Enter UNDERLY! CAUSE (Disease or injuthat initiated events resulting in death) LAS	diate ING ary	Sus 8 DUE TO	COR AS A CONSECUTION	DUENCE OF	7:		A raines given in	Part I. 24s. WAS AN PERFOR		0	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
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BY PHYSICIAN: MEDICAL	cause. Enter UNDERLY! CAUSE (Disease or Inju that initiated events resulting in death) LAS PART II. Other algnifica 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Guilleria 5 G 2 Accident 3 Suicide 6 G 4 Homicide	D MEDICAL Pending Investigation Could not be determined Personal Private Physics Could not be determined Personal Physics CAL EXAMINER	DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO CONTRIBUTION TO TO TO TO TO TO TO TO TO TO TO TO TO	deeth but not not not not not not not not not no	DOA DOA 28b. TIMI INJ	OTHER: 4 Nursin EURY M Writnest, factory	26. PLACE 26. PLACE ing Home 5 8c. INJURY WORK? 1 YES y, office	E OF DEATH (Ch	Part I, 24a. WAS AN PERFORM 1 YES 2 eck only one) 8 Other (Specify) 28d. DESCRIBE HOW II City or Town, State) to the cause(s) end man time, date and place, and	NJURY OCC	CURED or Rural Roo ed. e cause(e)	MALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO		
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BE COMPLETED BY PHYSICIAN: MEDICAL	CAUSE (Disease of Injury CAUSE (Disease of Injury that Initiated events resulting in death) LAS PART II. Other algnifica 25. WAS CASE REFERRED TO EXAMINER? 1	diate ING ITY ant conditions O MEDICAL Pending Investigation Could not be determined TIFYING PHYSIC ICAL EXAMINER G OF CERTIFIER	DUE TO DUE TO	deeth but not not not not not not not not not no	DOA 28b. TIMINJ	OTHER: 4 Nursin E OF URY M At the time n, in my opin	26. PLACE 26. PLACE 39 Home 5 8c. INJURY WORK? 1 YES y, office e, date and nion, death	E OF DEATH (Che	Part I, 24a. WAS AN PERFORM 1 YES 2 eck only one) 8 Other (Specify) 28d. DESCRIBE HOW II City or Town, State) to the cause(s) end man time, date and place, and	NJURY OCCURN Number as stated due to the 29d, DATE	CURED or Rural Roo ed. e cause(e)	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO We Number, and manner as stated.		



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.											
16	1. DECEDENT'S NAME (First, Middle, Last)							2. DAT	E OF DEATH		YEAR	3. TIME OF DEATH
- 28	Harry	L.		hards	3				ch 12			3:20 P.M M
	4. SOCIAL SECURITY NUMBER 214-07-8918	5. SEX 6.	AGE (In yrs. les	t birthday)	MONTHS D	-	IF UNDER 24 HRS.		E OF BIRTH		Country	PLACE (State or Foreign
	9e. FACILITY NAME (If not institution, give st		02	YRS.	01 01711 700				728710			yland
Œ					LOCATION OF DE	EATH		9c. COUNT		EATH		
5	Memorial Hospita		OII		E	ast	OII			Tall	DOL	
DIRECTOR	Maryland Caroline Preston									10d. INSIDE CITY LIMITS?		
									1 YES 2 XNO			
A A	109. STREET AND NUMBER 23861 Griffith Road 21655							U.S				
BY FUNERAL	11. MARITAL STATUS	12. WAS DECEOENT E	VER IN U.S. AR	MED	13. WAS	S DECE	NDENT OF HISPAN	VIC ORIG	HN? (Specify Yes	L	4. RACE	— American Indian.
Ϋ́	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE WAR		10			Ify Cuban, Mexica		o Rican, etc.)			White, atc. White
	15. DECEDENT'S EDUC	ATION	40- 05	OFFICE								WILLE
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gi	Do NOT us	USUAL OCCU vork done during retired.)	ng most	of working		Sb. KIND OF BUS			
P.	8th	conege (I-4 of 5 +)		Truc	ck Dr	ive	er		Fransp	orta	tio	n
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NA				W	illiams
BE	Clarence	Richards							Murph	_		rds
2	190. INFORMANT'S NAME (Type/Print) Mrs. Betty Van	Cahaile					Number or Rural F					
	20a, METHOD OF DISPOSITION	SCHAIK			FDISPOSITIO					CATION - C		MD 21655
	1.X. Suriel 2 Cremation 3 Remo	eval from State	cemetery, crei	matory or or	ther place)	17 37	6 Of	16				aryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		0 00	22. NA	ME AND	ADDRESS OF FA	CILITY				
	Muleuf 7.	Esken			Fra:	mpt Box	om-Haw 43, F	kir ede	ıs-Esk ≥ralsb	ow Fu	une:	ral Home 21632
	23. PART I. Enter the disease, or c shock, or heart feliure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Bower J	on each line.	Le		a mode	e of dying, suci	h ea ca	rdiec or reapi	ratory arrea	et,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		R AS A CONSEC									
AL C	PART II. Other aignificant conditions	contributing to de	ath but not re	eaulting i	n the under	rlying	cause given in	Part I.	24a. WAS AN			WERE AUTOPSY FINDINGS
	Acute Pichones	y Evenin							PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDIC	CHRONIC ObsTRUCT		vary D	remen	S							1 TYES 2 NO
ä	House Fibruson	as - Celes	iè									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:		CE OF DEATH (Che					
HYS	1 YES 2 NO 27. MANNER OF CEATH	28e. OATE OF IN.		28b. TIM		Home	5 Residence		ter (Specify) ESCRIBE HOW II	HIBY OCCI	DED	
ВУ Р	1 Netural 5 Pending	(Month, Day,	Year)		URY	WORK	(?	200. 0	Lyonibe non n	100111 0000	NED	
	2 Accident Investigation 3 Suicide 6 Could not be determined	26e. PLACE OF IN building, etc.	IJURY — At hor (Specify)	me, term, s	treet, factory,	office			CATION (Street a y or Town, State)	nd Number or	Rural Ro	oute Number,
COMPLETED	29a. CERTIFIER only 2 MEDICAL EXAMINER											and menner as stated.
ш	29b, SIGNATURE AND THILE OF CRUTIFIER						Pac. LICENSE NUM		Т			Month, Day, Year)
00	Mall h						043001				121	and the second second
2	30. NAME AND ADDRESS OF PERSON WHO				0						/	
	31. DATE FILED (March, Opr. Year)	32. REGISTRAR'S	SIGNATURE	445	भवा	aro-1	(MO 211	101				
	12 Mar MAK 16 393		Davidson	Bud	00							

TOTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TANT: If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-16 Rev 1/89

Pages 1, 2, 3 should

permit.

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	AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
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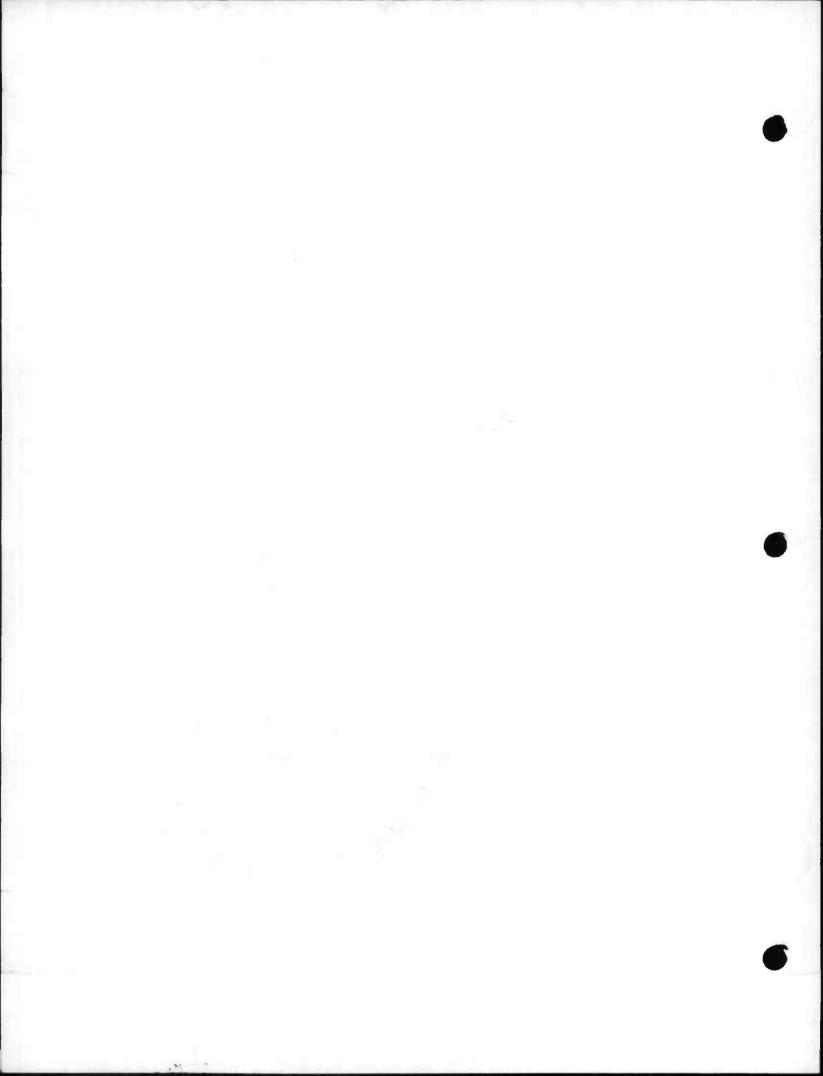
filled in

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIEN 3 FOR STATE REGISTRAR REG. NO.

2. DATE OF DEATH 3/12/93
MONTH DAT 2 33 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) DORIS Mae REED 3, TIME OF DEATH Dor Neco 130 DOM A SOCIAL SECURITY NUMBER 5 SEY & AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 L 214-78-0983 YRS 59 10/08/33 Hagerstown, MD 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 25441 Cascade RD Cascade Washington RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Washington 1 TES 2 NO Cascade 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? of in by the funeral director, page 5 should be detached for use as the burial-transit of removal. 25441 Cascade Road 21719 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify Specify: White BY 3 Widowed 4 Divorced COMPLETED 16a, DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe nentary/Secondary (0-12) College (1-4 or 5 +) 11 Teacher's Aide Public Schools 17. FATHER'S NAME (First Middle Leat) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 15 Reuben Heiston BE Ada Mae Curry notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Reed Sr 25441 Cascade RD, Cascade, MD 21719 ě 204. METHOD OF DISPOSITION

1 X Burlet 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 4 Donation 5 Other (Specify) Bethel Church Cemetery 13/16 Cascade, MD examiner 21. SIGNATURE OF FUNERAL SERVICE-LICENSEE 22. NAME AND ADDRESS OF FACILITY Grove Funeral Home, Inc. James a. Bowlersof 50 S. BRoad ST Waynesboro, PA 17268 James A Bowersox shows any injury, or other traumatic event, the medical 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Finel n and completely filled to burial, cremation, disease or condition resulting in death) mouthe Jaroma DUE TO (OR AS A CONSEQUENCE OF) MEDICAL CERTIFICATION Sequentially list conditions, QUE TO (OR AS A CONSPOLIENCE OF) if any, leading to immediate cause. Enter UNDERLYING the attending physician in Mental Hygiene prior to CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO a de COMPLETION OF CAUSE Signed Health a 1 YES 2 W eneprovescular Accident 1 - YES 2 - NO been : has be Dept. (PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h EXAMINER? HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA ne 5 Tesidence 8 Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c. Item 28 Is marked, 1 Natural 5 Pending Investigation 1 YES 2 NO BΥ After 1 death 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be determined DIRECTOR: Nours after of 4 Homicide 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSEITAL TO THE FUNERAL DE filed within 72 h 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner es stated. 29d. DATE SIGNED (Month, Day, Year) BE Robert Bull MI enoral Myclas march 14 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Prin Potime Hogers Town 32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year)
MAR 1 6 1993



Items 23 Part I,27, per MEO, G-698, 4/2/93 gn 93 08931

		1 - STATE REGISTRAR	SIAIE UF N	MANTE					DEAT		MEN IA	REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, Last)										OF DEATH		3	TIME OF DEATH
		Brea	Sam			Randolph				03	01	199	3	10:18 A.M	
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE	(In yrs, last bir	**	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	(Mont	OF BIRTH h, Day, Year)		8. BIRTHPL Country)	ACE (State or Foreign
Pin		none 9a. FACILITY NAME (If not institution, give	1 🗆 M 2 💢 F		35day	YRS.	1	5			Jan	26, 19	993	Mary	
3 should	œ			~ ~ ~					R LOCATIO		HTA			ITY OF DEA	
1. 2.	СТОВ	Washington C	ounty H	osp	ıta⊥		На	gers	stow	n			Was	hing	ton
Pages	DIRE	The second secon						R LOCAT				10d, INSI			Dd, INSIDE CITY
permit. F		Maryland Wa	shington			ŀ	lager								YES 2 NO
ii.	FUNERAL	1822 A. Abbey L	ane					101.	217				US		AT COUNTRY?
215-0020 attending physician. Ise as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		IN U.S. ARMED 2 ZNO DATES	D	1	f yes, spe	cify Cuba	F HISPAN n, Mexica Specify	in, Puerto Rican, etc.) Biec				- American Indian, Vhita, atc.	
2121 of atte	COMPLETED	15. DECEDENT'S EDI (Specify only highest gradi Elementary/Secondary (0-12)		·)	16a. DECED (Give k He. Do	kind of v NOT us	USUAL Of work done one retired.)	CUPATIO	ON st of workin	g		KIND OF BUS	SINESS/IND	USTRY	
-AND the hospita detached	Š	17. FATHER'S NAME (First, Middle, Last)							18. MOTH	ER'S NA	ME (First,	Middle, Maiden	Sumame)		-
# E E	l III	Franklin	Randolph									Durham			
be retained by e 5 should be motified at		19a. INFORMANT'S NAME (Type/Print) Whitney Durham	1						nd Number / Lan			stown			21740
BALTIMORE, after death. Page 6 may be y the funeral director, page moval. ical examiner must be it		20a, METHOD OF DISPOSITION 1 \(\bar{\Delta} \) Burlal 2 \(\bar{\Delta} \) Cremation 3 \(\bar{\Delta} \) Ren 4 \(\bar{\Delta} \) Donation 5 \(\bar{\Delta} \) Other (Specify)	noval from State	20b	b. PLACE AND metery, cremate edar L	DATE O	of DISPOS	ITION (Na	me of al Pa		3/4	E 20c. LO	CATION — (City or Town	
ALTIMOF leath. Page 6 m funeral director. xaminer mus		21 SIGNATURE OF FUNERAL SERVICE LI	CENSER	/	1).	-									
BAL TIN ter death. Pag the funeral di wal. si examiner		22. NAME AND ADDRESS OF FACILITY. Gerald N. Minnich Funeral Home 305 N. Potomac Street Funeral Home Hagerstown, Maryland													
24 hours filled in I ion. or re		23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Lipid	P n	ach ilna.	nia	ì	the mod	da of dyle	ng, suci	as can	diac or respi	retory arm	est,	Approximate interval Between Onset and Death
executed n and com to burial,	TION	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):													
e par a	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	c. DUE TO	(OR AS A	A CONSEQUE	NCE OF	F):								
1 4 8 0	ᇤ	resulting in death) LAST	d								_				
0 8 5 E		PART II. Other significant condition	ns contributing to	death b	but not resu	iting i	n tha un	deriying	cause g	iven in	Part i.	24s. WAS AN	AUTOPSY	24b. W	ERE AUTOPSY FINDINGS
AL RECORD requires that the been signed by the library and I have any In	IN: MEDICAL											1 YES 2	MED?	AN CO	MILABLE PRIOR TO DMPLETION DF CAUSE F DEATH? YES 2 NO
FIN	12	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			—т	OTHER		ACE OF DE	ATH (Che	ick only or	10)			
16	E	1 YES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 1		-	DOA Bb. TIM	4 🗆 Num		5 G Rec	sidence					
After Manual Man	BY P	1 Natural Tending 2 Accident Investigation	(Month, Da	ny, Year)		INJ	M	1 🗌 Y	RK? ES 2	NO	28d. DES	CRIBE HOW IN	JURY OCC	URED	
ATTEN ATTEN S after 28 i	ETED	3 Suicide s Could not be 4 Homicide detarmined	28e. PLACE Of building, o	F INJURY etc. (Spec	/ — At home, cify)	form, s	treet, fact	ory, affice			28f. LOC City	ATION (Street a or Town, State)	nd Number	or Rural Rout	e Number,
TO THE HOSPITAL OR TO THE FUNERAL DIRECTORY BE fied within 72 hours IMPORTANT; If Itom	COMPL	one) 2 MEDICAL EXAMINE							eth occure	d at the	time, date				nd manner as stated,
TO THE OT THE INPORT	TO BE	296. SCHATURE AND TITLE OF CERTIFIE	Shoule	2					29c. LICE	C. M					onth, Day, Year) 1993
	۴	MAMADONES OF PERSON WITH A D.	O COMPLETED CAUS					ree	t, E	Balt	imo	re, M			21201
		31. DATE FILED (MONTH, Dey, Year) MAR 1 (, 1993	92 REGISTRAN	R'S SIGN									-		

I ENDING PRINCIAN: HE MAY EQUINES THAT THE DEADLY CENTIFICATE DE EXECUTED WITHIN 24 HOURS ATTENDED BY THE POSPITAL OF ATTENDING PHYSICIAN.	een signed by the attending physician and completely filled In by the	ath w	marked, or item 23 shows any injury or other traumatic event, the medical examinar must be notified at nace
N. ING	cate h	State	Item
SICIAL	certifi	the :	L or
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UNION	: After	r death	S m
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	1 - STATE DAVID RELIGIOUS DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR DAVID RELIGIOUS REGISTRAR DAVID RE
9	1. DECEDENT'S NAME (First, Middle, Last) DAVID NMN REIFSCHNEIDE 2. DATE OF DEATH MONTH DAY SEAR S. SEX B. AGE (In urs. leaf bibliodic) EINNER 1 YEAR F. RATE OF DEATH A. SOCIAL SECURITY NUMBER S. SEX B. AGE (In urs. leaf bibliodic) EINNER 1 YEAR F. RATE OF BUSY T. DATE OF BUSY M. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic) F. SEX R. AGE (In urs. leaf bibliodic)
	248-42-324 1MM 2 F 81 YRS. MONTHS DAYS HOURS MIN. 2-16-1912 Maryland
TOR	98. FACILITY NAME (If not institution, give street and number) 90. CITY, TOWN OR LOCATION OF DEATH 90. CITY, TOWN OR LOCATION OF DEATH WESIDENCE OF DECEDENT WESIDENCE OF DECEDENT
DIRECTOR	10a. STATE 10b. COUNTY Maryland Prince George's Brandywine 10c. CITY, TOWN OR LOCATION Brandywine 10d. INSIDE CITY LIMITS? 1 □ YES 2 □ NO
FUNERAL	100. STREET AND NUMBER 16000 McKendree Road 101. ZIP CODE 20613 USA
ВУ	11. MARITAL STATUS 1
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6 College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Forklift Operator US Government
BE CO	17. FATNER'S NAME (First, Middle, Last) Henry Reifschneider 16. MOTNER'S NAME (First, Middle, Maiden Surname) Margaret Elizabeth Bradley
5	196. INFORMANT'S NAME (TyperPrint) Ella M. Reifschneider 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16000 McKendree Rd., Brandywine, Md. 20613
	20s. METNOD OF DISPOSITION 1 Sp Burisi 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Date 20b. PLACE AND DATE Of DISPOSITION (Name of Campetery, Cremetory of other place) Trinity Memorial Gardens 3-18 Waldorf, Md.
	21. SIGNATURE OF FUNERAL SERVICE LICEMET & G. Brohawn M0005B22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home P. O. box 156, Waldorf, Md. 20604
	23. PART I, Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reepiratory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition as EXPLUSIVE Carely of Ward Low
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):
i: MEDICAL	PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PROPOSE AMPLIABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMPLIABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Ingestigate 2 ER/Outpetient 3 DOA 4 Number Norm 5 Residence 4 Cobe (Count)
ВУ РНУ	1 Pes 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, Year) 28b. TIME OF NJURY NORK? 2 Accident Investigation Netural
	3 Suicide 8 Could not be detarmined 28a. PLACE OF INJURY — At home, larm, street, lactory, offica building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the hasis of examination and/or investigation, in-my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as stated.
TO BE	THE SHARK TURE AND TITLE OF CERTIFIER WHITE AND TITLE OF CERTIFIER WHITE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) \$\Bigs 3/12/93
F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MANDUTCHEHR MOASSER M.D. 16005 CRAIN HWY RT301 BRAND VWINE, Md. 20613
	31. DATE FILED (Month, Day, 1997) 32. REGISTRAR'S SIGNATURE Julia Davidson Randelle.

3. TIME OF DEATH

REG. NO

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)William Alexandria Scott

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ATTENDING PHYSICIAN. The law requires that the death certificate he executed within 24 by
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MONTH WILLIAM 93ª 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 12-15-1902 IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 217-28-1643 1 📈 M 2 🗌 F 90 Maryland detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number PRINCE C 9b. CITY, TOWN OR LOCATION OF DEATH CCINTON, Md. GEORGE DIRECTOR 10c. CITY, TOWN OR LOCATION 10a STATE 10b. COUNTY 10d. INSIDE CITY LIMITS? 1 YES 2 NO Maryland Prince George's Clinton FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6207 Parkview Lane 20735 USA 11. MARITAL STATUS
Never Merried 2 Merried 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 25 NO If yea, specify Cuban, Mexicen, Puerlo Rican, atc.) ₽¥ 1 TES 2X NO Specify: Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Farmer Agriculture 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) James Thomas Scott notified at BE (Clara Wenck 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Elizabeth Mulliken 6207 Parkview Lane, Clinton, Md. 20735 8 20e. METHOD OF DISPOSITION
1 ☐ Burlal 2X Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION --- City or Town, State must Huntt Crematory or other place) 5 Other (Specify) 3-19 Waldorf, Md 21. SIGNATURE OF FUNERAL SERVICE BEENETE WN MO0053 22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home filled in by the O. Box 156. Waldorf. Md. medical I. Enter the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, such se cerdiec or respiratory errest, Approximate shock, or heart fellure. List only one ceuse on each line. 9 **IMMEDIATE CAUSE (Fine)** Onset and Death the disesse or condition pletely OUE TO (OR AS A CONSEQUENCE OF): event, resulting in death) 5 DAYS crem and col burial, DUE TO (OR AS A CONSEQUENCE OF): traumatic MEDICAL CERTIFICATION Sequentielly list conditions, 2 If sny, leeding to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSCOURNCE OF): CAUSE (Diseese or Injury other that initiated events resulting in death) LAST 6 the atten Mental F shows any injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuee given in Pert I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS and PERFORMEO? AVAILABLE PRIOR TO CUR OSODS13 COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO PHYSICIAN: has be Dept. 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate to the State I, or Item Hem EXAMINER? HOSPITAL: OTHER: etlent 2 ER/Outpetlent 3 DOA me 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) D-RECTIDR: After this cer hours ther death with the 28c. INJURY AT WORK? this c 28d. DEŞCRIBE NOW INJURY OCCURED 1 Netural 5 Pending 1 YES 2 NO B 2 Accident 3 Suicide 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 201. LOCATION (Street and Number or Rural Route Number, City or Town, State) e Could not be determined COMPLETED 4 Homicide hours 29e. CERTIFIER

(Chack ank)

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. 2 __ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 3-18.93 2 WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) M.D. 11701 LIVINESTON Rd. #101 Ft. WASHINGTON, Md NEDZBALA 32. REGISTRAR'S SIGNATURE
Suita Davidon Randelle

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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		REGISTRAR 1. DECEDENT'S NAME (First,	Adirection (part)	THOTE	T 77 77	CERTIF		OF	DEA	ГН		REG. NO.			100 0 3
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		4. SOCIAL SECURITY NUMB	DER .	5. SEX		rs. last birthday)	IF UNDER 1	YEAR	IF UNDER	24 HRS.		E OF BIRTH	1 \ 77	_	PLACE (State or Foreign
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Sapes	DIRECTO	10a. STATE	10b. COUNTY			10c. CI1	Y, TOWN OR	LOCATI	ON						10d. INSIDE CITY LIMITS?
регтік. Pages		MARYLAND 10s. STREET AND NUMBER	MON	TGOMERY		SI	LVER S	_							1 YES 2 NO
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020 physician, burial-transit	볼	2608_WOODEI	JGE RU	12. WAS DECEDEN	NT EVER IN U.	S. ARMED	13. WA	S OECE	209		IC ORIG	IN? (Specify Yes	or No	USA	— American Indian,
	BY	1 Never Married 2 X 3 Widowed 4 Divo		FORCES? 1	YES 2	2 NO	If y	es, spe	cify Cubii 2 X NO	n, Mexica	n, Puerto	Ricen, etc.)	0,10-	Black, Specifi	White, etc.
r attending	ED	15. OEC (Specify only	EDENT'S EDU	CATION completed	16	Sa. OECEDENT'S	USUAL OCCI	UPATIO	N et of workin		16	b. KINO OF BUS	SINESS/IND		1111
Q = 5	APLET	Elementary/Secondary (0		College (1-4 or 5	+)	life. Do NOT u	se retired.) MEMAKI		t or working	· V					
MARYLAND 2 retained by the hospital 5 should be detached to notified at once.	COMPL	17. FATNER'S NAME (First, M. NICHOLAS	,		11							Middle, Maiden	,		
MARY retained b 5 should	O BE	190. INFORMANT'S NAME (7)		FRIEDRIC	н	19b. MAILING	ADDRESS (S	Street en		or Rural F		GOERL noer, City or Town		Code)	
2 8 0	٢	CORNELIUS (LIVAN			WOODEI								AND 20906
		20e. METNOD OF DISPOSITI	n 3 🗆 Reme	oval from State	cemeter	ACE AND DATE	ther place)				OA	TE 20c, LO	CATION —	Olty of Tov	rn, State
Dage of		4 Donation 5 Other 21. SIGNATURE OFFUNERA		ENSEE	_ J GAT	E OF H			METE		B/1	2 SILV	ER SE	PRINC	,MARYLAND
BALTIMOR ter death. Page 6 ma the funeral director, p yval.		> Line	stly	Sy. Co	uel	ill	FRAN	CIS	J.	COL	LINS	FUNER			
in 24 hours af ely filled in by nation, or remo	23. PART. Enter the diseases, of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliuted List only one ceuse on each line. IMMEDIATE CAUSE (Fins)							Approximete Interval Between Onset and Death							
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	CATION	Sequentially list conditi if any, leading to immed cause. Enter UNDERLY!	diate		1 1)	INSEQUENCE O	F): Pnieu	40.		<u> </u>					
e by all	FIC	CAUSE (Disease or inju		C. T.	(OR AS A CO	INSEQUENCE O	<u> </u>	/ ///	OVICE						
OL 등 등급 O	CERTIFI	resulting in deeth) LAS	T (d											
S, de de de de de de de de de de de de de	- 1	PART ii. Other significe	nt condition	s contributing to	death but	not resulting	in the unde	rlying	Ceuse o	iven in	Part i.	24a, WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
RECORDS, F requires that the death seen signed by the atte of Health and Mental shows any injury, (MEDICAL	Alcoh	me ile	-								PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
EC equires en sign of Hea	MEI	(- 1	DF DEATH? 1 YES 2 NO
AL RE e law requ has been Dept. of	ÿ														
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N O PHYS	ВУР		Pending Investigation	(Month, D	Day, Year)	IN.	M .	WOF] NO			.,,,,,		
DIVISION OF VITAL RECORD: OR ATTENDING PHYSICIAN: The law requires that the DIRECTOR: After this certificate has been signed by th hours after death with the State Dept, of Health and M item 28 is marked, or litem 23 shows any inji	8	3 Suicide 8	Could not be determined	28e, PLACE O building,	OF INJURY — stc. (Specify)	At home, ferm,	streel, factory	, office			28f, LO City	CATION (Street e y or Town, State)	nd Number	or Rurel Ro	oute Number,
DI TAL OR AL DIRI 72 hour	COMPLET			CIAN: To the best of											and manner ee stated.
HOSPITAL FUNERAL Within 72 RTANT: If	_	29b. SIGNATURE AND TITLE						-	29c. LICE						Month, Day, Year)
TO THE FUNER TO THE FUNER be filed within	O BE	gum	2m							3789			▶ 3	9.	92
10	5	30. NAME AND ADDRESS OF	0.0	Λ .				- 1c		m.O	ma	00			
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. 13**		31. DATE FILED (Month, Day,	9 3	Gichie	Davidson	-Andel	2								

permit. Pages 1, 2, 3 should

detached for use as the burial-transit

attending physician and completely filled in by the funeral director, page 5 should be nrtal Hygiene prior to burial, cremation, or removal.

sen signed by the attending ph of Health and Mental Hygiene

this certificate has been with the State Dept. of I

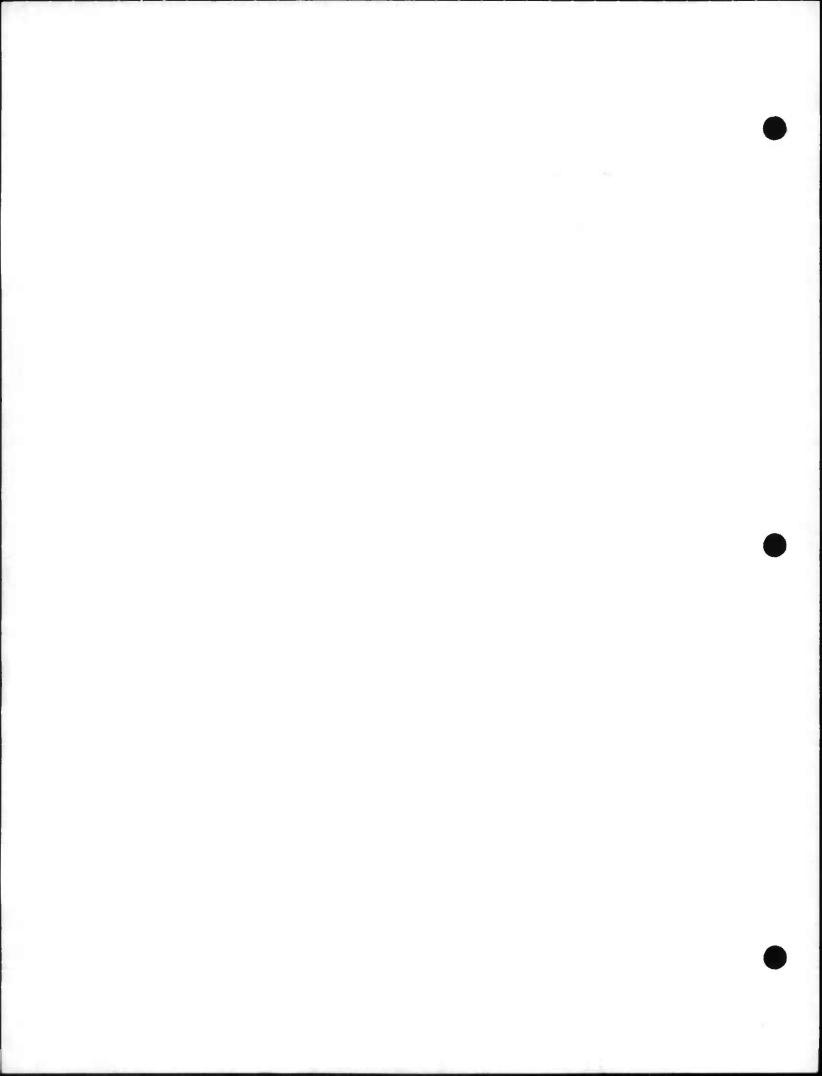
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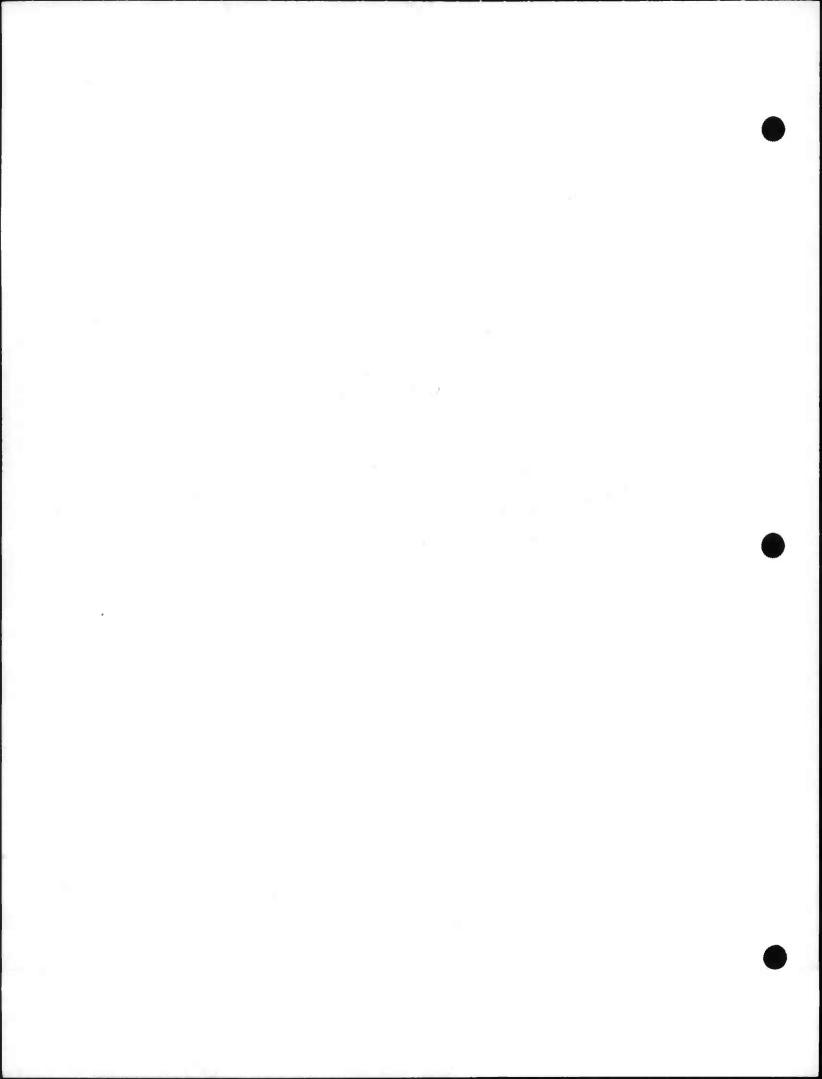
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH SPAULDING 1993 EAR March 15. Jennie 4. SOCIAL SECURITY NUMBER 5. SEY 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. 1 M 27 F 577-05-5797 AUG.12,1893 WASHINGTON, D.C. 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Prince George DIRECTOR Lanham Doctors Community Hospital RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY N/A N/A WASHINGTON, D.C. 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 913 HAMLIN STREET, N.E. 20017 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuban, Maxican, Puerto Rican, etc.)
 U YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Marri Specify: BY 3 X Widowed 4 Divorced WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest gr Elementary/Secondary (0-12) College (1-4 or 5+) 8 HOUSEWIFE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Ħ JOHN ALEXANDER BRANSON BE MARY ISABELLA STOREY notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 VERONICA S. TRAINUM 7613 TOPTON STREET NEW CARROLLTON, MARYLAND 20784 9 20a. METHOD OF DISPOSITION

1 X Burial 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1 X Burlel 2 Cremetion 3 4 Donation 5 Other (Specify) CONGRESSIONAL CEMETERY 3/17 WASHINGTON, D.C. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, or heart failure. List only one cause on each line. 500 UNIVERSITY BLVD., W. SIL.SPR., MD. 20901 medical Approximate interval Betwe IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition resulting in death) necesson event. traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other that initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 TES 2 NO 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem HOSPITAL: OTHER: 1 YES 2 NO 1 Pinpetient 2 ER/Outpetient 3 DOA ne 5 🗆 Residence 6 🗆 Other (Specify) 6 27. MANNED OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked. 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 28 4 Homicide If item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De files within 7. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. ATUJIE AND TITLE OF CENTIFIES 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE attent. 1 MO-3 2 PERSON WHO COMPLETED CAUSE OF PEATH (ITEM 27) (Type, Print) Ruderman KEnilWOTTH Ave. 6510 Riverdule MO Md 20737 31. DATE FILED (Month, Day, Year) 32. GEGISTRAR'S SIGNATURE 16 '93 MAR



(TX		1 - FOR STATE OF MARYLAND / DEPARTMENT CERTIFICATE			93 0	8936
• 69	-	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Leet) JEANNIE MARIE SAUNDERS JEANNIE SAUNDERS JEANNIE SAUNDERS	S DEATH	2. DATE OF DEATH MONTH DARCH 12.	NY, YEAR	3. TIME OF DEATH
B M	1	220-70-6584 1 35 YRS.	DAYS HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) FEB 26 19	8. BIRTN Country	PLACE (State of Foreign INGTON, D. C.
1. 2, 3 should	CTOR		ETHESDA	DEATN	9c. COUNTY OF DI	
permit. Pages 1.	L DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OF MARYLAND MONTGOMERY SILVER	SPRING			10d. INSIDE CITY LIMITS? 1 YES 2 NO
transit	FUNERAL	11613 LeBARON TERRACE	101. ZIP CODE 20902	ANIC ORIGIN? (Specify Yea	USA	
21215-0020 sl or attending physician. for use as the burial-tran	D BY FL	1 Never Married 2 Married 3 Wildowed 4 Divorced FORCES? 1 YES 2 NO If IF YES, GIVE WAR OR DATES 1	yes, specify Cuban, Mexic YES 2X NO Spec	an, Puerto Rican, atc.)	Black Specifi	— American Indian, , Whita, atc. y: THTTE
14 m 5	COMPLETE	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) REALTOR		16b. KIND OF BUS	BINESS/INDUSTRY	
MARYLAND 2 retained by the hospital 5 should be detached to notified at once.	BE COM	17. FATHER'S NAME (First, Middle, Lest) WILLIAM W. SAUNDERS		AME (First, Middle, Maiden A FRANCES PI	-	
. 2 2 0	TO B	WILLIAM W. SAUNDRS (FATHER) 11613 LeBA	RON TERRACE		PRING, MAR	
SALTIMOR death. Page 6 ma e funeral director, p al. examiner must		FR.	CEMETERY AME AND ADDRESS OF F	3/17 SIL	RAL HOME,	IG, MARYLAND
within 24 hours aftiplietely filled in by it cremation, or remorent, the medica		23. PART I. Enter the diseases, pr complications that coused the deeth. Do not enter to shock, pr heart fellure. List only one couse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):	he mode of dying, au	ch ee cerdlec pr reepl	ratory arreat,	Approximete interval Between Onset and Death
P.O. BOX 68 th certificate be executeding physician and if Hyglene prior to bur or other traumattic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. ULBUTC faull out to for As A consequence of: c. ULBUTC faull DUE TO for As A consequence of: d. Currlus of	rynds Leive	and o	due	
L RECORDS aw requires that the c s been signed by the ept. of Health and Me can be seen signed by the	MEDICAL	PART II. Other algnificent conditions contributing to death but not resulting in the und	eriying ceuse given in	1 Part I. 24a. WAS AN PERFOR	MED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
VITA JAN: The Tificate Re State or item	YSICIAN:		28. PLACE OF DEATN (Cong Nome 5 Residence	8 Other (Specify)		
ION OF NDING PHYSIC I: After this cell r death with the	ВУ РНУ	1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation 3 Sulcide	8c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE NOW IN		ruda Mumbar
DIVISION OR ATTEN DIRECTOR: INDUCE after Illem 28 II	PLETED	Suicide Could not be detarmined building, etc. (Specify) 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time.		City or Town, State)		
TO THE ACCUSAN	E COMP	One) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opi		e time, data and place, and		
A PARTIE	TO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	D19-	185	▶ 3/13/	1993
		FRAUKE WESTPHAL, M.D. 809 VEIRS MILL ROAD 31. DATE THE MAPPING DOWN DOWN DOWN DOWN DOWN DOWN DOWN DOWN	D ROCKVILI	E, MD. 208.	51	



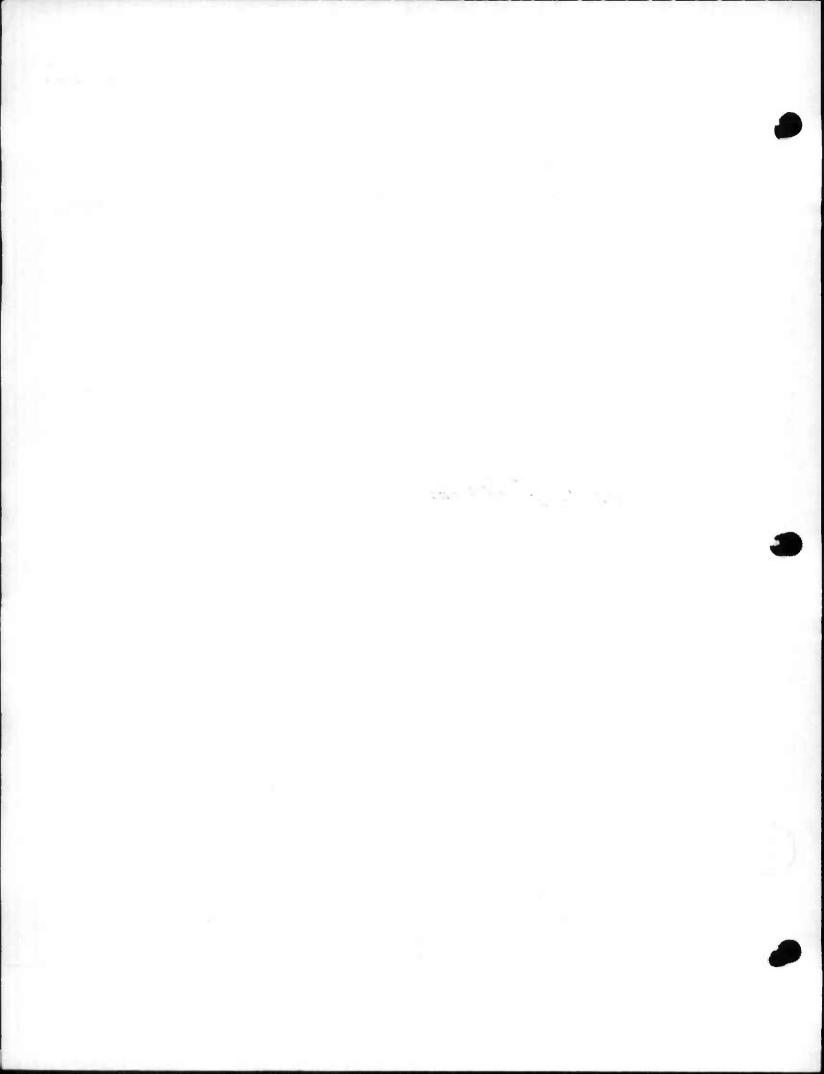
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	TIEGIGITIVIT									1120:110		_			
ļ	1. DECEDENT'S NAME (First,		TD ED G							2. DATE OF DEATH		YEAR	3. TIME OF DEATH		
1	ROGER JOSE					,					1993		1720 M		
	4. SOCIAL SECURITY NUMB 218-88-0151		5. SEX	6. AGE (In yrs. I	est birthday) YRS.	IF UNDE	DAYS	HOURS	MIN,	7. DATE OF BIRTH (Month, Day, Year) Feb. 23,	1977	Country	PLACE (State or Foreign yland		
	9e. FACILITY NAME (If not in	stitution, give s	street end number)			96. CIT	r, TOWN	OR LOCAT	ION OF DE		9c. COU	INTY OF DE	•		
OB	9101 Jones		Road			Ch	Chevy Chase Montgo					ntgom	ery		
5	RESIDENCE OF DEC	10b. COUNT	v		10c CI	Y. TOWN	OB LOCA	TION					10d. INSIDE CITY		
DIRECTOR	Maryland		tgomery		111111111	evy							LIMITS?		
A	10e. STREET AND NUMBER						10	H. ZIP COE	E	_	10g. CIT	IZEN OF W	HAT COUNTRY?		
E	9101 Jones	Mill I	Road					208	15		Uni	ted S	tates		
FUNERAL	11, MARITAL STATUS 1 Never Married 2	Married		NT EVER IN U.S. A 1 YES 2 WAR OR DATES		13.	If yes, s		en, Mexica	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No—		- American Indian, White, etc.		
₩ B	3 Widowed 4 Divo	rced	IF TES, GIVE	WAR ON DATES			I 🗆 TE	S 2 MAG	эрвскі	γ.		Bla	ck		
COMPLETED		EDENT'S EDU y highest grade		16e. I	Give kind of	Work done	during m	ION lost of work	ing	18b. KIND OF BU	SINESS/IN	DUSTRY			
9	Elementary/Secondary (0 C)	1-12)	Collega (1-4 or 5	+)	stude:					III ah C	a la a a	1			
M	17. FATHER'S NAME (First, M	liddle (set)		,	stude.	II C		I 40 MO	THER'S NA	High S		Τ			
5	David L. Sa									s High San					
BE	190. INFORMANT'S NAME (7			1.	19b. MAILIN	G ADDRES	S (Street			Route Number, City or You		io Code)			
2	David Sande	**								Chevy Ch			0815		
	20a. METHOD OF DISPOSIT	ION			E OF DISPO							- City or Tov			
	4 Donetion 5 DOther	(Specify)		_ Balt	place) imor					matory La	urel	, MD			
	21. SIGNATURE OF FUNERA	L SERVICE LI	_			22	MCGu	AND ADDR	Fune	ral Servic	e. T	nc.	20012		
	con en	41	200	ebbis	est.					Ave. N.W.	,		n, D.C.		
	23. PART I. Enter the ti shock, or h IMMEDIATE CAUSE (Fin	sart fallure.	complications th List only one ca			not ente	r the m	oda of d	ying, auc	ch as cardiac or reap	iratory a	rreat,	Approximata interval Between Onset and Daath		
	disease or condition resulting in death) a. GUNSHOT WOUND											ACUTE			
	DUE TO (OR AS A CONSEQUENCE OF):														
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):														
5	cause. Enter UNDERLY CAUSE (Disease or inju		c	O (OR AS A CONS	EQUENCE (OFI:									
E	that initiated events reaulting in death) LAS	т	d.			·									
	PART II. Other significa	ant condition	no contribution t	n death but no	0 manufelas	le the s	a de els de		aluan la	Part i. 24s. WAS AF	AUTOREN		WERE AUTOPSY FINDINGS		
SAL	PART II. Other significa	ent conditio	ns contributing t	o daeth but no	c resulting	ini tue c	moerryn	ng cause	given in	PERFO	RMED?	240.	AVAILABLE PRIOR TO COMPLETION DF CAUSE		
EDICAL										1 _ YES	2 7 10		DF DEATH?		
Σ													1 NES 2 NO		
A	25. WAS CASE REFERRED 1	TO MEDICAL					26. 1	PLACE OF	DEATH (C	heck only one)					
Sic	EXAMINET?		HOSPITAL: 1 Inpatient 2	☐ ER/Outpatient	3 DOA	OTHE		me 5	Masidence	8 Other (Specify)					
PHYSICIAN:	27. MANNER OF DEATH		28a. DATE C	OF INJURY Day, Year)	28b. TI	ME OF		NJURY AT		28d. DESCRIBE HOW	INJURY O	CCURED			
ВУ	1 Netural 5 2 Accident	Pending Investigation	3	8 93		PM			NO	GUNSHO	TU	UOU	NA		
								28f. LOCATION (Street City or Town, State		er or Rural F	loute Number,				
	4 Homicide	determined		1	101	ME					#	10			
COMPLETED	29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner ee stated.														
00	2 IN MET			examination end/	or investigat	llon, In my	opinion,	, death occ	ured at the	e lime, date end place, e					
BE	296. SIGNATURE AND PITC	E OF CERTIFIE	0//	1. /	100	7		29c. Li	CENSE NU	MBER	29d. D/	ATE SIGNED	(Month, Day, Year)		
6	30. NAME AND ADDRESS O	E PERSON W	HO COMPLETED OF	ME OF DEATH-O	TEM 27) (Tor	ne Print)		10	07	099		3-8	-93		
	FRANKIS C	11.	XL6 10	215 Fe	RNW	00)	S R	8 9	BE	THESDA	Mi	5	2817		
	31. DATE FILED (Month, Day)	9 3	Julia	Day de	Randal	2									

BALTIMORE, MARYLAND 21203-3146

ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the flowers after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should after death with the State Dept, of health and Mental Hygiene prior to burial, cremation, or removal. WISION OF VITAL RECORDS, P.O. BOX 13146,

5 5 5



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Day. ***9**3

M.D.

32. REGISTRAPIS SIGNATURE

June Navidon fordell

Neil Meade,

31. DATE FILED (Month)

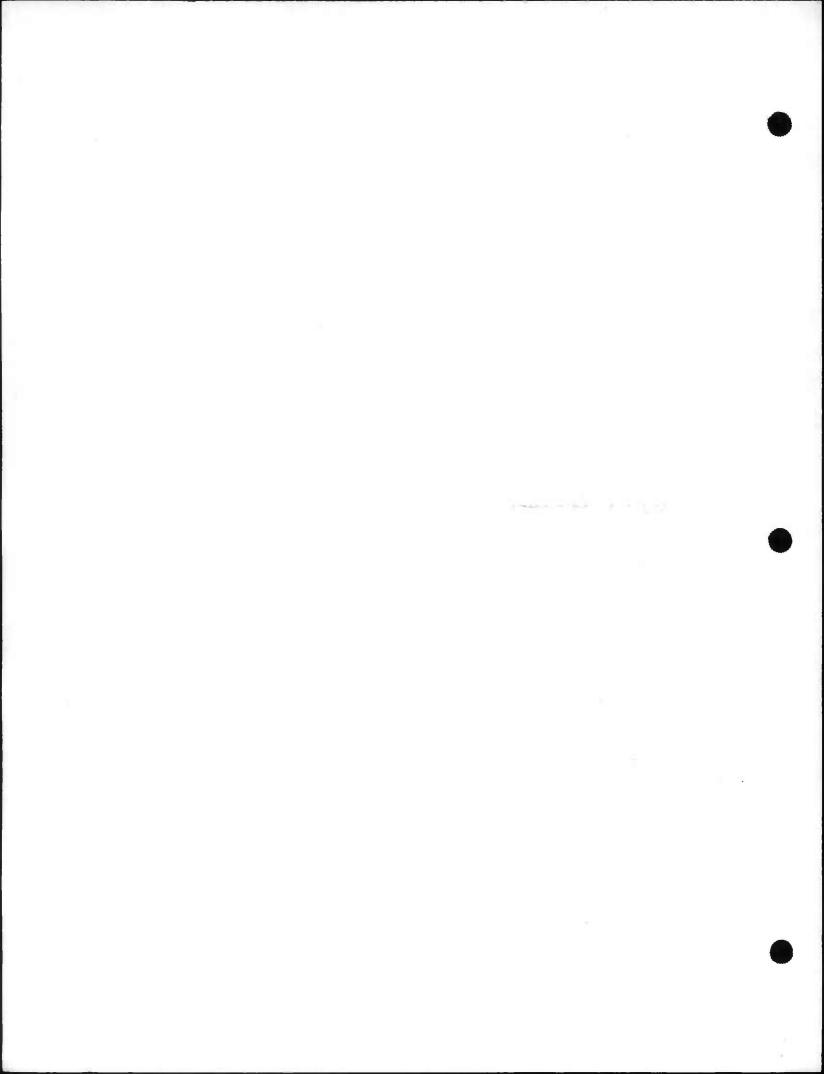
	1	FOR STATE REGISTRAR		STATE OF I	MARYLA			TMENT OF) ME		HYGIEN REG. NO		93	08938			
		1. DECEDENT'S NAME (First,										DATE OF		MY _	YEAR	3. TIME OF DEATH			
1		Florer	nce Li	illian S	Snyder							03	- 10) - 0	3	(080 M			
		4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE In	yrs. last bi	irthday)	IF UNDER 1 YEA		DER 24 HR	_	DATE OF	BIRTH		6. BIRT	HPLACE (State or Foreign			
	- 1	579-40-742]	L	1 □ M 2√XF	80	0	YRS.	MONTHS DAY	HOUR	S MIN		ct.		912		hington, D.C.			
1		9a. FACILITY NAME (If not in	nstitution, give s	treet and number)				9b. CITY, TOW	N OR LOC	ATION OF	DEATH	1		9c. COU	NTY OF				
TOR		Greater Lau	irel Be	eltsville	Nurs	sing	Cr	Laur	el					Pri	nce	George's			
DIRECTOR		10a. STATE	10b. COUNTY					, TOWN OR LO								10d. INSIDE CITY LIMITS?			
1	11.	Maryland		ce George	e's		Be]	tsvill	e							1 TYES ZONO			
4		10e. STREET AND NUMBER							101. ZIP C	ODE				10g. CIT	IZEN OF	WHAT COUNTRY?			
FUNERAL	i	4502 Elmwc	ood Roa	ad					2	0705)			Un.	ited	States			
		11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN	U.S. ARME	ED.	13. WAS I	ECENDEN	T OF HIS	PANIC (ORIGIN?	Specify Ya		14. RAC	E — American Indian, ck, White, stc.			
	- 11	1 Never Married 2		FORCES?	VAR OR DAT	ESTYNO			specify Co		xican, P ecify:	uerto Ric	an, etc.)		Spec				
B		3 Widowed 4 Dive	orced						M		,					White			
		15. DEC	CEDENT'S EDU ly highest grade	CATION				USUAL OCCUP		add to a		16b. K	IND OF BL	SINESS/IN	DUSTRY				
l li	1	Elementary/Secondary (College (1-4 or 5	+)	Iffe. D	o NOT us	e retired.)	most or wo	nung									
ᆵ		12 years				Sale	espe	erson				pı	civat	e					
COMPLETED		17. FATHER'S NAME (First, M	Aiddle, Last)						18. M	OTHER'S	NAME	_		Sumame)					
		Charles Edw	vard Fr	citts					F	lore	nce	T.	Jern	an					
H		19a. INFORMANT'S NAME (19b. I	MAILING	ADDRESS (Stre	_						ip Code)				
2	2	Florence Re	**					as #10							,				
	-	20e. METHOD OF DISPOSIT			20h			SITION (Name of	cometany (rametan.	٥,		20c I	OCATION -	City or 1	own State			
		1 Burial XX Cremetic	on 3 🗆 Ram	oval from Stata		other place	9)	515,110		,	O.								
	∦	4 Donation 5 Other 21. SIGNATURE OF FUNERA		CENGEE	_ Met	rrob	DITI	an Cre	AND ADD		EACILI	TV	TALE	xand	ria,	Virginia			
		1	R	e s San				Dona	ld V	. Bo	rgw	ardt				e, P.A. , Md. 20705			
	7	23. PART I. Enter the d	diseeses, or	complications the			th. Do i									Approximate			
	[Liet only one ce	use on ee	ch line.										Interval Between Onset and Death			
		IMMEDIATE CAUSE (Fi	nei	4	OV	1/M	MAN	YA	1.05	MV		MIC	1 DA	5,5					
		resulting in death)	→	e. Due To	OR AS A	CONSECU	ENCE O	F):	VIL	7117		111)	611	16					
	. 1					MA			RAC	100	50	110	1051	(
CERTIFICATION		Sequentially list condition		b	OR AS A	* * *			100		, _	VU)	1011						
I		If any, leading to imme																	
1 12	2	CAUSE (Disease or Injuthat initiated events	ury	DUE TO	OR AS A	CONSEQU	ENCE O	F):											
E		resulting in death) LAS	ST	2															
	3			d															
		PART II. Other significa	ent condition	na contributing to	deeth bu	t not res	uiting	in the underi	ying ceus	e giver	in Pa	rt il. 2		N AUTOPSY	24	b. WERE AUTOPSY FINOINGS AVAILABLE PRIOR TO			
MEDICAL		ning	6705	mist	LII	VS	>					_	1 YES	1		COMPLETION OF CAUSE OF DEATH?			
		ALZI	Itani	MSUS	1119	10	50							4		1 YES 2 NO			
		HANA	MI	B1()	CU	<u> </u>						-							
N A		25. WAS CASE REFERRED 1	TO MEDICAL	1/10				2(. PLACE O	E DEATH	/Check	only one							
2	2	EXAMINER?		HOSPITAL:			7.000	OTHER:											
PHYSICIAN:	2	1 YES 2 NO		1 □ Inpatient 2			26b. TIN	4 Nursing	INJURY A					INJURY O	CCUBED				
दे। म	- 111	Y _	Pending		Day, Year)			JURY	WORK?	2 X NO		ou. DEGO	MBL NOW	INSONT C	CCONED				
5		2 Accident 3 Suicide	Investigation Could not be	26e. PLACE	OF INJURY	At hom	e, ferm,	atreet, factory,	office		20		TION (Stree Town, Stat		er or Rura	I Route Number,			
E A	- 15			Demany	are tobacu	.,,						Jay Or	.orri, Gent	-,					
ě	- 15	4 Homicide	determined									29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.							
5	- 15	4 Homicide 29a. CERTIFIER (Check only one)	RTIFYING PHYS													(s) and manner as stated.			

29d. DATE SIGNED (Month, Day, Year)

3-11-93

29c, LICENSE NUMBER D19220

9811 Mallard Drive, Suite #205 Laurel, Maryland 20708



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WISION OF VITAL RECORDS, P.O. BOX 687	
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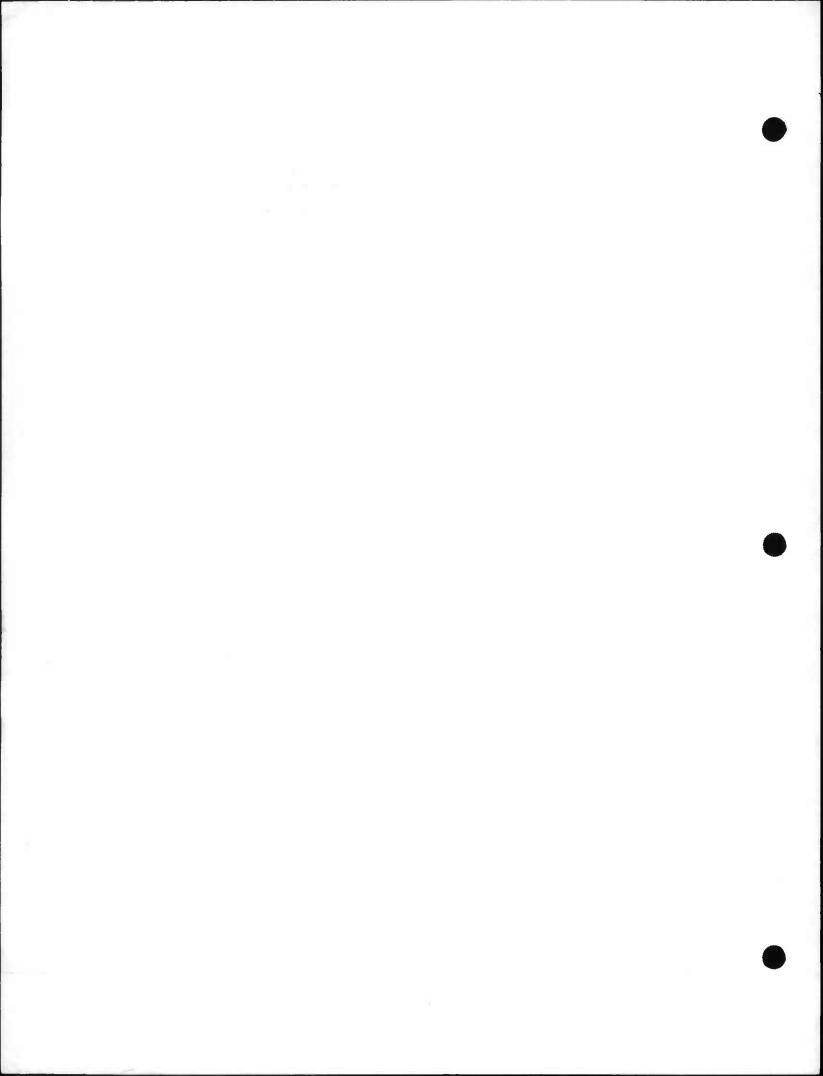
31. DATE FILED (Morith, Day, Year)
MAR 16 '93

31. RECESTRAN'S SIGNATURE

Fund Davidson Randall

	FOR_	STATE OF MA	RYI AND / DEP	ARTMENT (OF HEALTH AND	MENTAL HYCIEN	EQ?	2 0	8939			
	1 - STATE REGISTRAR		CERT	FICATE	OF DEATH	REG. NO		, 0	0,00			
	1. DECEDENT'S NAME (First, Middle, Last)		- 2777	N THE STREET		2. DATE OF DEATH	AY		3. TIME OF DEATH			
	Elizabeth Joan	Shumate	517	4.11		монтн. 3 - /	- ک	93	1:22 A.M			
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. last birthde	//		7. DATE OF BIRTH		8. BIRTHE	LACE (State or Foreign			
	577-44-5735	1 🗆 MXX F	58 YRS	. MONTHS D	AYS HOURS MIN.	Jan. 18, J	L935	Penr				
-	9a. FACILITY NAME (If not institution, give st			96. CITY, TO	OWN OR LOCATION OF D	EATH		INTY OF DE				
OF	Holy Cross Hospital Silver Spring Montgome.											
EC	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c.	CITY, TOWN OR	LOCATION				10d. INSIDE CITY			
DIRECTOR	Maryland Monto	pomery		ilver S					LIMITS?			
AL	10e. STREET AND NUMBER				101. ZIP CODE		10g. CIT		HAT COUNTRY?			
FUNERAL	11620 Stewart La	ane, #101			20904		Uni	ted S	tates			
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVEN FORCES? 1 IN IF YES, GIVE WAR	YER IN U.S. ARMED	13. WAS	S DECENDENT OF HISPA	NIC ORIGIN? (Specify Years, Puerto Rican, etc.)	s or No—	14. RACE Black.	- American Indian, White, atc.			
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES TA		YES 2 X NO Specif			Specify	·			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	(Give kind	T'S USUAL OCCU	JPATION ng most of working	16b. KIND OF BU	SINESS/IN	DUSTRY				
) LE	Elementary/Secondary (0-12)	College (1-4 or 5+)		ruse retired.) Wrapper		priva	+0					
M	8 Years 17. FATHER'S NAME (First, Middle, Last)		11000	wiapper		ME (First, Middle, Maiden						
	William Henry Sto	offel				na Phillip	,					
BE (19a. INFORMANT'S NAME (Type/Print)		19b, MAIL	ING ADDRESS (S	treet and Number or Rural			p Code)				
٩	Brenda Davis		2K	Laurel	Hill Road	Greenbelt	, Ma	rylan	d 20770			
	20e. METHOD OF DISPOSITION 1 Burlel 2 Vermation 3 Remo	ovel from State	20b. PLACE AND DA	TE OF DISPOSITE	ON (Name of	DATE 20c. LC	CATION -	City or Tow	m, State			
	4 Donation 5 Other (Specify)		Metropol	îtan Cr	rematory 3	/12/93 Ale	exand	ria,	Virginia			
	21. SIGNATURE OF FUNERAL SERVICE LIC		wards	Don	me and address of Fa ald V. Bor 10 Powder M	gwardt Fun			P.A. Md. 20705			
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
	IMMEDIATE CAUSE (Final				1				Interval Between Onset and Death			
	disease or condition resulting in death)	M	W1301	11	ACIDO	212			are week			
		DUE TO (OR AS A CONSEQUENCE OF):										
NO	Sequentially list conditiona,	DUE TO (OR	AS A CONSECUENCE	OF					16/10090			
AT	if any, leading to immediate cause. Enter UNDERLYING	6	ANGR	ENUC	15 3	OWEL		48 Hour				
FI	CAUSE (Disease or Injury that Initiated events	PUE TO (OR	AS A CONSEQUENCE	OF):	TIC VA	- 1 1	0 ./	20 4 0 0				
CERTIFICATION	resulting in death) LAST	14719	eur sci	Euri	nc va	SCULATA	11/5	SAFE				
-	PART II. Other significant conditions	contributing to de	eth but not resulting	o in the unde	riving cause given in	Part I. 24a. WAS AN	ALITTAREV	245	WERE AUTOPSY FINDINGS			
2	777	n × -1-				PERFO	RMED?		MAJLABLE PRIOR TO COMPLETION OF CAUSE			
	RHEWA	MADIO IN	Ann	mi	2	1 YES :	S. CYCNIO		OF DEATH?			
7	REMA	2 ms	UFFIC	(En) 0	4				, La rest			
¥	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (CA	neck only one)						
SIC	1 VES 2 NO	HOSPITAL: 1 Inpetient 2 ER	VOutpatient 3 🗆 DO	OTHER:	Home 5 🗆 Residence	6 Other (Specify)						
PHYSICIAN: MEDICAL	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJ (Month, Day,)		INJURY	C. INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OC	CURED				
BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF IN	JURY — At home, far			281. LOCATION (Street	and Numbe	or Aural Br	usta Numbac			
E	4 Homicide 8 Could not be	building, atc.	(Specify)			City or Town, State,						
PLE	29a. CERTIFIER (Check only	IAN: To the best of my	knowledge, death occ	urred at the time	, date end place, and due	to the cause(e) and ma	nner as ste	ited.				
COMPLETED	one) 2 MEDICAL EXAMINE								and manner ee stated.			
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER 2	29d. DAT	TE SIGNED	Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALLES	NE DEATH OTEN OF	one Outor's	P 330	WEER Y		3//	2 (73			
	UTB5 2xct	6 Euros	PE, MID.	2/2	D352	EL Royk	n.	SILV	En SIRING			

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NG P	fter t	eath	E
END	JR: A	ter d	90
AA	RECT	ILS at	m 2
TO THE LIGHTIAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending ph	TO THE FOURTH CHELTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the b	2 hou	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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31. DATE FILED (Month, Day, Year)

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign -3803 IF UNDER 1 YEAR 7. DATE OF BIRTH 28 1 M 2 F HOURS WASHINGTON, D.C 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR 5610 WISCONSIN AVENUE #407 MONTO OMERN RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION MONTGOMERY CHEVY CHASE **MARYLAND** 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? WISCONSIN AVENUE #407 20815 5610 UNITED STATES 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married If yes, specify Cuban, Mexican, Pu 1 TYES 2 NO BY Specify. 3 Widowed 4 Divorced WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) **BUILDING INDUSTRY** 5+ BUILDER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at BENJAMIN SHERMAN ELIZABETH KRUPSAW BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 5610 WISCONSIN AVENUE #407 - CHEVY CHASE, MD. 20815 ROSE SHERMAN pe 20s. METHOD OF DISPOSITION
1 Thudge 2 Cremation 3 Removal from State
4 Donation 5 Office (Specify)
21. SIGNATURE OF TUNITAL SERVICE LICENSEE 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must JUDEAN MEMORIAL GARDENS 3/11 OLNEY, MARYLAND examiner 22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. Jagan 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852 lar medical Enter the diseases, of complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line. 23. PART I. Enter the disc Approximate interval Between Onset and Death IMMEDIATE CAUSE (Finel the disease or condition resulting in death) ANIGR OF 2 mg event, DUE TO (OR AS A CONSEQUENCE OF) traumatic BY PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMEO? AVAILABLE PRIOR TO Item 23 shows any OF COMPLETION OF CAUSE NEDR ROSTATE 1 | YES 2 10 5 Draw Cuaro 1 YES 2 NO HEART SASE 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 10 1 Inpetient 2 ER/Outpetient 3 DOA me 5 PResidence 8 Other (Specify) 5 27. MANNED OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED If item 28 is marked, 1 Natural 5 Pending investigat M 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CENTIFIER 29d. DATE SIGNED (Mgnth, Day, Year) 29c-LICENSE NUMBER BE MA 11485 tun 2 30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Rype, Print)

8830

Lulia Davidson Pandall

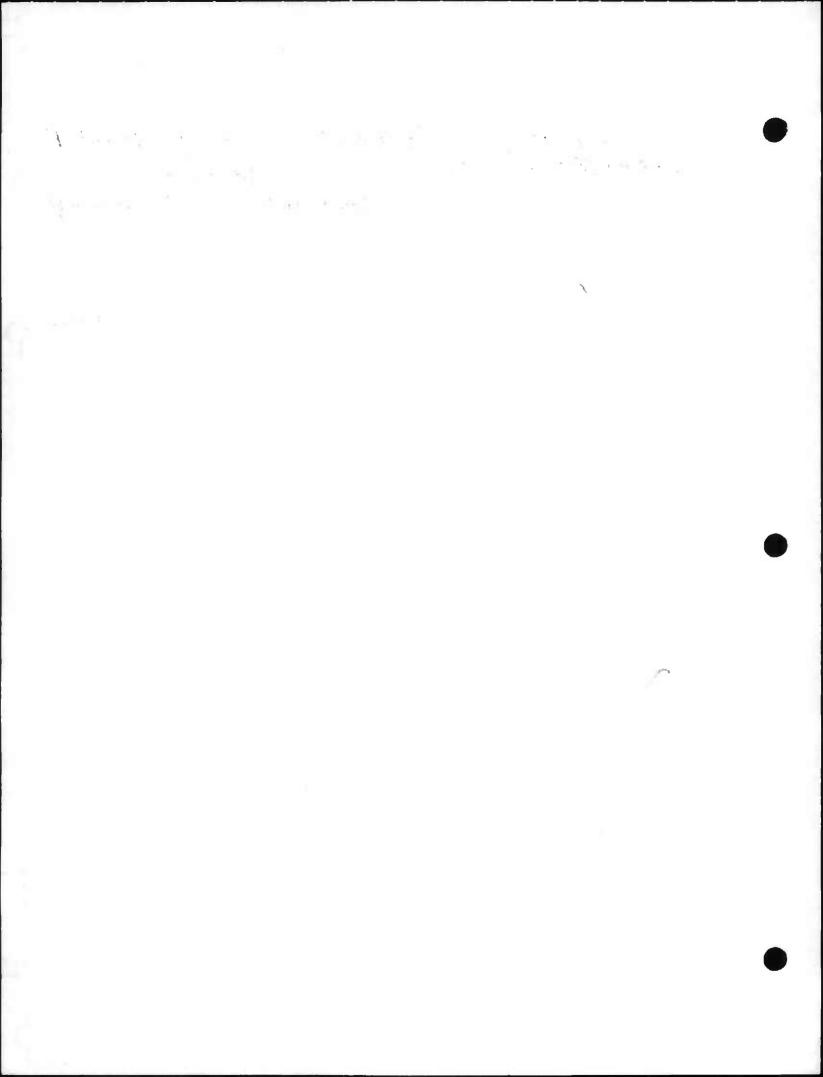
32. REGISTRAR'S SIGNATURE

AMBRON

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20910

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3. TIME OF DEATH

5:40 PM

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

TOLMAN

5. SEX

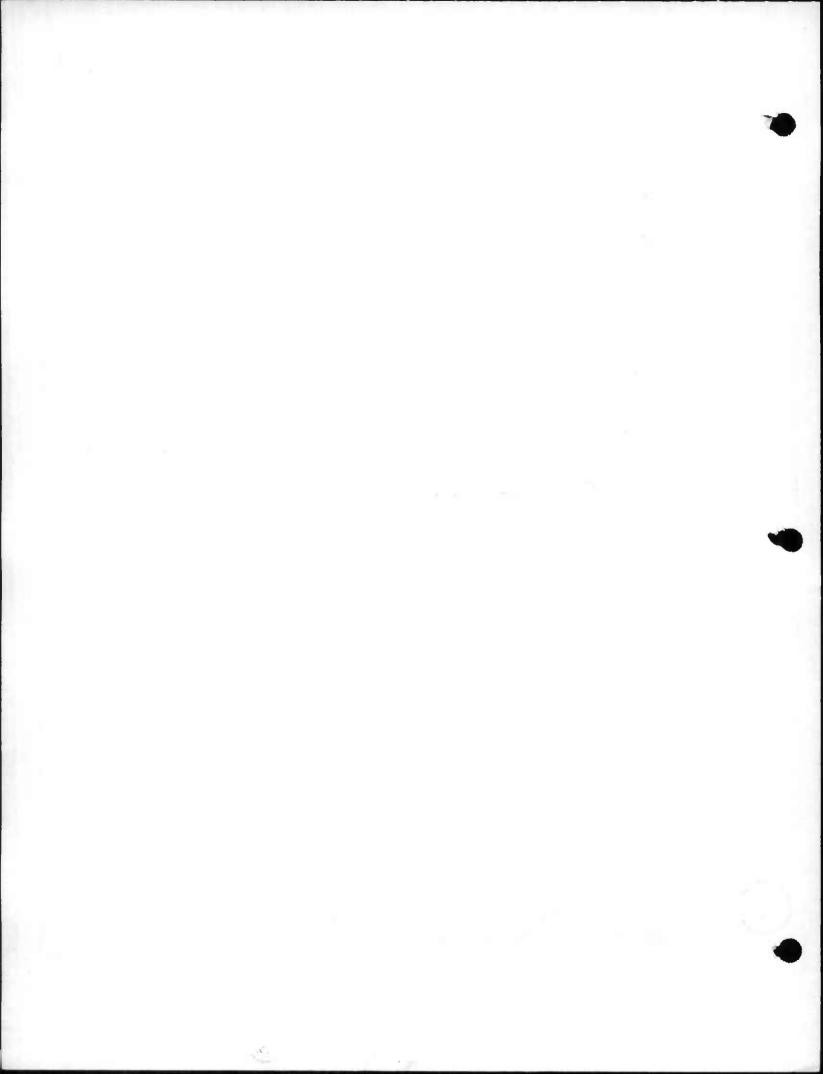
DIVISION OF VITAL RECORDS, P.O. BOX 13146,
DIVISION OF VITAL RECORDS, I
DIVISION OF VITAL
DIVISION

		4. SOCIAL SECURITY NUMBER 089-05-4210	5. SEX 6	. AGE (In yrs. last		IF UNDER 1 YEAR		(Mc	TE OF BIRTH onth, Day, Year)		Country)	E (State or Foreign
pind		9a. FACILITY NAME (If not institution,	10.00	9b. CITY, TOWN OR LOCATION OF DEATH					, 1896 NEW YORK			
2, 3 should	OR	HEBREW HOME O	F GREATER WA	ASHINGT		ROCKVI					TGOME	
-	DIRECTOR					TOWN OR LO					1	INSIDE CITY LIMITS?
Ë		MARYLAND MON 100. STREET AND NUMBER	IGUMERI		RU	CKVILI	101. ZIP CODE			1 YES 2 NO		
an. ransit pe	FUNERAL	6105 Montrose Road 20852							UNITED			STATES
ending physician. as the burial-transit permit. Pages	ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WAI	YES 2 X N	2 NO If yes, spec			CENDENT OF HISPANIC ORIGIN? (Specify Year pecify Cuban, Mexicen, Puerto Rican, etc.) 5 2 X NO Specify:			Specify:W	
atten use as	TED	15. DECEDENT'S (Specify only highest		(G/	ve kind of wo	SUAL OCCUPA	TION most of working		16b. KIND OF BUS	INESS/INDU	STRY	
ospital or attended for use	APLET	Elementery/Secondery (0-12)	College (1-4 or 5+)	(1-4 or 5+) Homema					Own Home			
by the hospital be detached at once.	TO BE	17. FATHER'S NAME (First, Middle, Les HARRIS SILEC						'S NAME (Firs	ot, Middle, Malden	Surname)		
urns after death. Page 6 may be retained by the hospital or attending physician, in by the funeral director, page 5 should be detached for use as the burial-train removal. edical examiner must be notified at once.		190. INFORMANT'S NAME (Type/Print) JEFFREY BOLOTIN					Cresce					20007
		20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State	20b. PLACE other ple BARON	OF OISPOSIT	TION (Name of	cemetery, cremator	ry or		cation - ci		New York
ter death. Page 6 mis the funeral director, wal.		21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	ne	-		ANSKY-G		RG MEMO	RIAL	CHAPE!	LS, INC. D 20852
executed within and and completelydd or bunial, cremation, or matic event, the m	CERTIFICATION	23. PART I. Enter the diseases abook, or heart fall IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	a. PNCL DUE TO (C DUE TO (C		DUENCE OF)): 	moda of dylng,	, auch an c	ardiac or reapi	ratory arrea	at,	Approximate interval Between Ongat and Daat Aday S
equires that the den signed by the of Health and Me	MEDICAL	PART II. Other algorificant cond	CINUST				ring cause give	en in Part i	24a. WAS AN PERFOR 1 YES 2	RMED?	AWAI CON OF I	LABLE PRIOR TO PIPLETION OF CAUSE DEATH?
He se h	SICIAN:	25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO	HOSPITAL:	Em/Outration 4 0		отные:	PLACE OF DEAT					
NG PHYSICIAN fler this certifi- eath with the marked, or	PHYSICI	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF II (Month, Day	JURY	26b. TIME	OF 28c.	IOMe 5 Reside	28d. I	DESCRIBE HOW I	NJURY OCCU	RED	
DR ATTENDING P DIRECTOR: After thours after death	red BY	2 Accident Investigs 3 Suicide 6 Could no 4 Homicide determin	28e. PLACE OF building, at	INJURY — At ho	me, ferm, et	reet, factory, o		261. L	OCATION (Street (lity or Town, State)	t end Number or Rural Route Number, e)		
E 35 =	COMPLET	onel	PHYSICIAN: To the best of m									manner ee stated.
TOTHE HOSPI TO THE FUNER TO THE WITHIN	O BE C	29b. SIGNATURE AND TITLE OF CER	Nadanan	מוא, או)		29c. LICENS	9160	,	29d. DATE ▶ 3	SIGNED (Mor	1th, Day, Year)
C)		30. NAME AND ADDRESS OF PERSON	N WHO COMPLETED CAUSE 3DALANG	MD (ITE	612/	Print) MO 1	TRUSE	10	ROCK	VIU	& M1	20852
_		31. DATE FILED MONTH Day Year 93	32. RIGISTRAN	SIGNATURE	andell							

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

A.K.A. TESSIE

2. DATE OF DEATH



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olcian. The law requires that the dearn certificate de executed within 24 hours after death. Page 6 may be retained by the hospital or attendin	s certificate has been signed by	the State Dept. of Health and Mental Hygiene prior to b	an it was 60 about mit mit met benede betreet bie benede betreet betre
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1. DECEDENT'S NAME (FI	rst, Middle, Last)			-				-			ATE OF DEATH			3. TIME OF DE	ATH
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4. SOCIAL SECURITY NU		5. SEX	6. AGE (/	in yrs. last bin	thday)	IF UNDER	1 YEAR	IF UNDER	24 HRS		arch J	1,19		HPLACE (State or	-
404-13-177		1½ M 2 🗆 F	39)	"	MONTHS	DAYS	HOURS	MIN.	Ju	Ly 29,1	953	Coup	aiwan	roreign
9a. FACILITY NAME (If no	Institution, give s	treet and number)				9b. CITY,	TOWN C	R LOCATI	ON OF DE	ATH		9c. CO	UNTY OF E	DEATH	
7328 Gold	Ring Te	errace				Der	wood	1				M	ontg	omery	
10a. STATE	10b. COUNT	r		10	Dc. CITY,	TOWN O	R LOCAT	ION		_			-	10d. INSIDE CI	ry
Maryland	Montg	gomery			_	rwoo	-							LIMITS?	
7328 Gold	Ring 7	Terrace					101	2085					USA	WHAT COUNTRY?	,
11. MARITAL STATUS 1 Never Married 2X 3 Widowed 4 Di	The state of the s	12. WAS DECEDED FORCES? IF YES, GIVE	1 TYES	2 NO)		f yes, spe	ENDENT Code	n, Mexica	n, Puer	IGIN? (Specify Yerto Rican, etc.)	a or No-	Spec	CE — American Inc ck, White, atc. city:	
		l .											(Orienta	<u> </u>
(Specify of	ecedent's edu only highest grade	completed)		16a. OECED (Give k	ind of wo	ork done o	during mo	IN st of workin	ng		16b. KIND OF BU	ISINESS/IN	DUSTRY		
Elementary/Secondary	(0-12)	College (1-4 or 5									1.0	4	4		
		4		Compu	ter	eng	ine	er			self e	mplo	yed		
17. FATHER'S NAME (First,								18. MOTI	HER'S NA	ME (Firs	st, Middle, Maide	Surname)			
Shei-Han	Shee							We	ei (Che	n				
19a. INFORMANT'S NAME	(Type/Print)			19b. M	AILING A	DDRESS	(Street a	nd Number	or Rural F	Route N	lumber, City or To	vn, State, Z	ip Code)		
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20a. METHOD OF DISPOS	ITION	2		PLACEAND			ITION (Na.	me of		I D	ATE 20c. L	CATION -	- City or To	own, State	
1 Buriel 2 Creme 4 Donation 9 Oth	er (Specify)	over truin State	ceme Fr	etery, cremeto			emai		3/	16/		ntwo			
21. SIGNATURE OF JUNE		espice // /		1.11	COL	22.	NAME AN	D AODRE				TATAT	DT D	UNERAL I	702/17
Mille	ill	1.11	e.												
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23. PART I. Enter the	diseasea, or o	complications the	at caused	the death.	. Do no	t enter	the mo	de of dy	ing, suci	h aa c	ardiec or reap	iretory a	rrest,	Approxir	
IMMEDIATE CAUSE (F	neart tellure.	List only one car	use on ea	nch line.										Onset ar	
disease or condition	illai	Pa	0	617	10	(AN	160	7					6 M	
resulting in death)		a. / // N	JOR AS A	EAT	ACE OF		7110	CER	\					6 190	WIIB
		552 10	(011 145 1	CONSEQUE	NOE OF).										
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if any, leading to imm cause. Enter UNDERL		DOE TO	(ON AS A	CONSCOUE	TCE OF):										
CAUSE (Disease or In		C	/OB AC A	CONSEQUE	10F 0F										
that initiated events resulting in death) LA	ST	30E 10	(UR AS A	COMSEQUE	VCE OF):										
		đ,													
PART II. Other algolific	cent condition	s contributing to	death bu	ut not resu	iting in	the un	deriving	couse o	iven in	Part I	24a, WAS AI	AUTOPSY	246	b. WERE AUTOPSY	EINUNCE
											PERFO			AVAILABLE PRIOR	R TO
										_	1 🗌 YES	NO NO		OF DEATH?	CHUGE
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l															
25. WAS CASE REFERRED EXAMINER?	TO MEDICAL	HOSPITAL:				OTHER		ACE OF O	EATH (Che	ck only	r one)				
1 YES 2 NO 1 Inpetient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)															
PART II. Other agnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY AWALABLE PRINT COMPLETION DOF DEATH? 1 YES 2 NO 25 NO 26 NO 27 NO 26 NO 27 NO 27 NO 27 NO 27 NO 27 NO 27 NO 27 NO 28b. TIME OF INJURY AT WORK? 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27 NO 28b. TIME OF INJURY AT WORK? 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28c. OATE OF INJURY M 1 YES 2 NO 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28b. TIME OF INJURY AT WORK?															
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4 Homicide	determined	bunuing,	are (apaci	"77						С	City or Town, State)			
29a. CERTIFIER	DETERMINE BARRIES	Olan To do					_								
		CIAN: To the best of													
2 U ME	OTUAL EXAMINE	R: On the besia of a	xamination	and/or inves	rigation,	in my o	pinion, de	ath occur	ed at the	time, d	lete and place, a	nd due to t	he cause(a) and manner as	stated.
296. SIGNATURE AND TITE	E OF CERTIFIER	01						29c. LICE	NSE NUM	BER		29d. DA	TE SIGNED	Month, Day, Year)
Kolu	MI	Wetage	, M	ND.				DC	18:	38	2		3/13	2/93	
30 NAME AND ADDRESS	OE BEDOON	COMPLETED L.	00.00.00				_	- <u>v</u> -		0			-1:	4:2	

. 3800 Reservoir Road Washington, D.C.

Delap, MD.

Robert

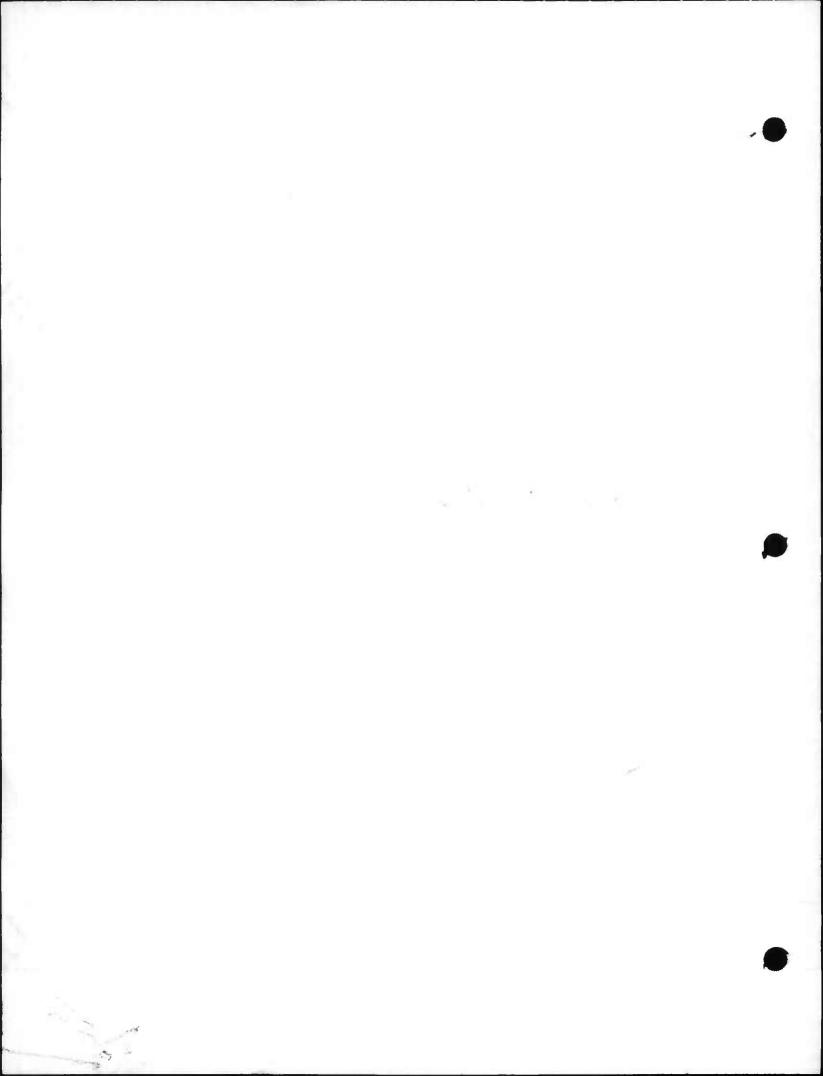
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withit, 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

	1 - FOR STATE REGISTRAR	STATE OF MARYLA			HEALTH AND N	MENTAL HYGIENE REG, NO.			
8	DECEDENT'S NAME (First, Middle, Last) SOCIAL SECURITY NUMBER 5.	SEX 8. AGE (h	S E	PH IF UNDER 1 YEAR	ANDS F UNDER 24 HRS.	2. DATE OF DEATH DAY	9,42	3. TIME OF DEATH 3. TIME OF DEATH INTHPLACE (State or Foreign	
	577-22-8956	K) M 2 □ F 69	YRS.	MONTHS DAYS	HOURS MIN.	July 22,19	Co	ountry) /irginia	
m	9a. FACILITY NAME (If not institution, give street and Suburban Hospital	and number)		96. CITY, TOWN OR LOCATION OF DEATH Bethesda 9c. COUNTY OF DI Montgon					
DIRECTOR	RESIDENCE OF DECEDENT			Decin			Honeg	Gomery	
REC	MD Montgo	omory	17.0	ockvil			10d, INSIDE CITY		
	100, STREET AND NUMBER				IOI. ZIP CODE		10a CITIZEN (1 TYES 2 NO	
ERA	11406 Rolling Hous	se Road			20852		USA		
BY FUNERAL	1 Never Married 2 Wherried	. WAS DECEDENT, EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DATE W. W. II	2 NO	If yes,	ECENDENT OF HISPANI apocify Cuban, Mexican ES 2 XNO Specify:		se or No— 14. RACE — American Indian, Black, White, etc. Specify: White		
TED	15. DECEDENT'S EDUCATION (Specify only highest grade company)	ON	16a. DECEDENT'S I	ork done during	TION most of working	16b. KIND OF BUS	INESS/INDUSTR	TY .	
COMPLETED	Elementary/Secondary (0-12) Co	ollege (1-4 or 5 +)	Loan Gu		e Officer	Vetera	ans Adm	in.	
NO.	17. FATHER'S NAME (First, Middle, Last)		-			ME (First, Middle, Maiden S	Surname)		
BE (Gus Stephanos					Karavitis			
5	19a. INFORMANT'S NAME (Type/Print) Maria S. Stephanos	S				Rd., Rockvi			
	20a. METHOD OF DISPOSITION 1 🖄 Burlal 2 🗆 Cremation 3 🗆 Removal	20ь.	PLACE AND DATE O		Name of	DATE 20c. LOC	ATION — City o	or Town, State	
	4 Donation 5 Other (Specify)	F		In Cem			entwood	l, MD	
	DO a in D	in 1			and address of fac ph Gawler	's Sons, In	ic.		
	23. PART i. Enter the diseases, or come	olications that caused	the death. Do n	5130	Wisconsin	Ave NW Wa	shingt	on DC 20016	
TION	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death of the condition resulting in death) DUE TO THE AS A CONSEQUENCE OF: DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
	PART II. Other aignificant conditions co	ontributing to death be	at not resulting in	n the underly	ng cause given in f	Part I. 24s, WAS AN	WITOPSY	24b. WERE AUTOPSY FINDINGS	
MEDICA	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NOT OF								
A N	25. WAS CASE REFERRED TO MEDICAL			-					
SICI	EXAMINER?	OSPITAL:	itient 3 DOA	OTHER:	PLACE OF DEATH (Che				
BY PHYSICIAN:	27. MANNER OF BEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	286. TIME INJU	OF 28c. I	NJURY AT WORK? YES 2 NO	28d. DESCRIBE HOW IN	JURY OCCURE	0	
□	3 Suicide a Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Special	— At home, farm, si	treet, factory, of	lice	281. LOCATION (Street as City or Town, State)	nd Number or Ru	iral Route Number,	
COMPLET	29a. CERTIFIER (Orisck only 2 MEDICAL EXAMINER: Or	To the best of my knowle much basis of sxamination						ise(s) and manner as stated.	
TO BE	240. BIOMATURE AND TITLE OF CERTIFIER	Jones	. Wh		29c. LICENSE NUM		≥ 1 6	NED (Month, Day, Year)	
-	30. NAME AND ADDRESS OF PERSON WHO CO Paul T. Noone, M.			,	Rockville	, MD 2085	2		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA		,		,	*		
	MAR 19 '93	Julia Davidson	Bonda 12		-				

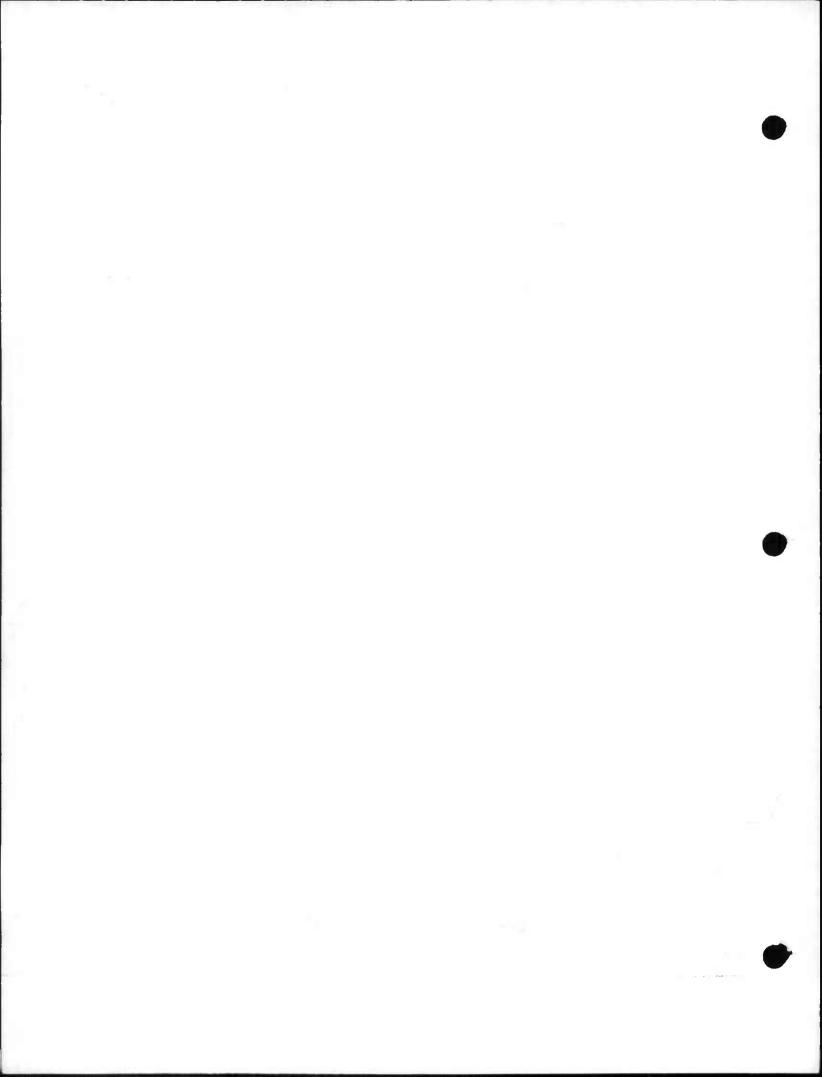


ICAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

JE VITAL RECORDS, P.O. BOX 68760,

É	TENDAMA PH	DR Ghee	ler death w	
DIV	TO THE HOSPITAL OR	FUNERAL DIRECT	within 72 hours	MPORTANT: If Item ;
V	TO THE	TO THE	be filed	IMPOR

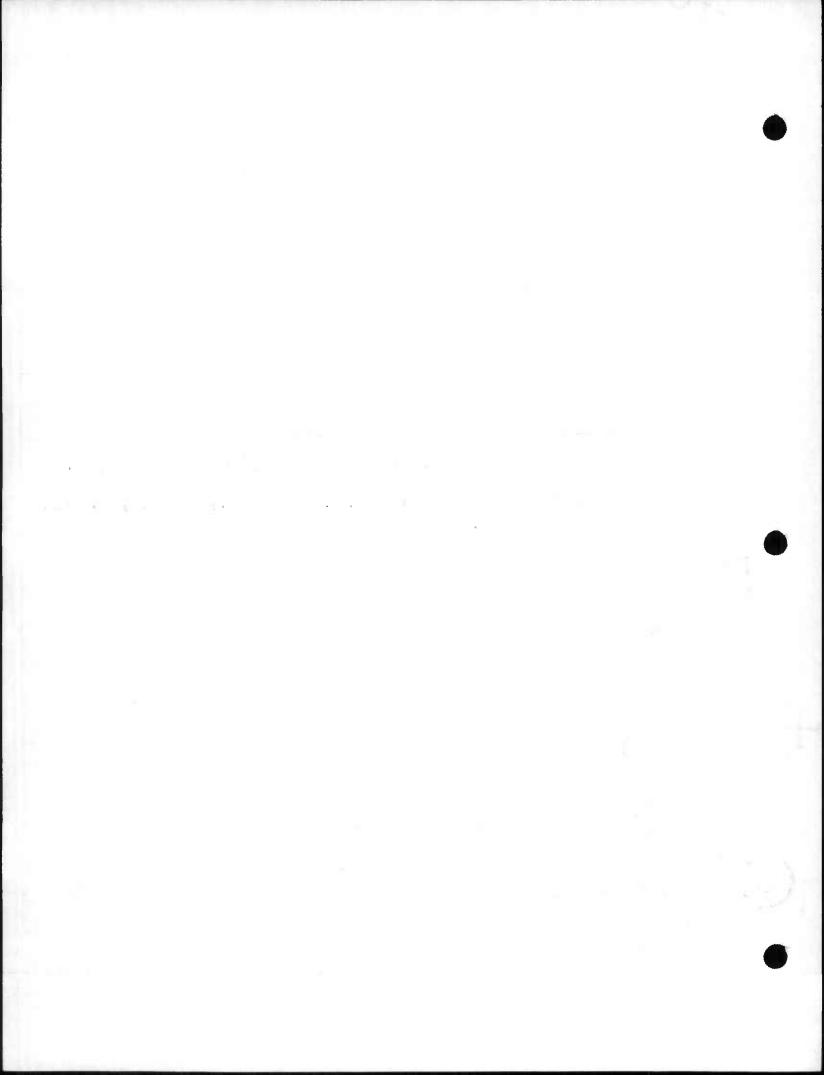
		1 - FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF HEAD		TAL HYGIENE REG. NO.			
	3	1. DECEOENT'S NAME (First, Middle, Lest)	PAUL RICH	_ D'	noop		ATE OF DEATH DAY	6-9E	A A - 2 -	
pin		4. SOCIAL SECURITY NUMBER 196-20-5498 9a. FACILITY NAME (If not institution, give st	1 M 2 □ F 65	YRS.	ONTHS DAYS HO	Uns Min. (A	ATE OF BIRTH forth, Day, Year) AY 19,192	27 PEN	RTHPLACE (State or Foreign untry) NSYLVANIA	
1, 2, 3 should	стоя	209 BLUFF TERRACE	reet and number)		SILVER SP			MONTG	OMERY	
mit. Pages	DIRE	MARYLAND MONT	GOMERY	2.9	SILVER SP				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
bunal-transit permit.	FUNERAL	209 BLUFF TERRACE	12. WAS DECEDENT EVER IN	U.S. ARMED		0902 ENT OF HISPANIC OR	ICINO (Paralle, Mar		USA	
as the buria	ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	2V NO	If yes, specify	Cuban, Mexican, Pue NO Specify:		8	ACE — American Indian, lack, White, etc. pecify: WHITE	
for use	PLETED	15. DECEDENT'S EDUK (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use i	rk done during most of retired.)		16b, KINO OF BUSI	NESS/INDUSTR	Y	
be detached at once.	E COMPL	17. FATHER'S NAME (First, Middle, Last) PAUL PHILIP S	3 1 SHOOP	I.B.E.W.		MOTHER'S NAME (Fil		Surname)		
5 should notified	TO BE	19a. INFORMANT'S NAME (Type/Print) CAROL JOANNE SHOO			DORESS (Street and No		lumber, City or Town,		AND 20902	
rector, page must be		20a. METHOD OF DISPOSITION 1 1 Burlal 2 Cremation 3 Remote 4 Donation 5 Other (Specify)	20b.	PLACE AND DATE OF	DISPOSITION (Name of place) VEN CEME		DATE 20c. LOC	ATION — City o		
the funeral director, oval.		21. SIGNATURE OF FUNERAL SERVICE LIC	G. Canal	ull	FRANCIS 500 UNI	J. COLLI VERSITY B	NS FUNER	RAL HOM		
or rem		23. PART I. Enter the diseases, or o shock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition	List only one cause on ea	ch line.	enter the mode of		cardlec or reapire	atory arrest,	Approximate Interval Between Onset and Death	
nd completely fille burial, cremation, atic event, the	_	resulting in death)		CONSEQUENCE OF):	Cane	e co				
ysician a prior to traum	ICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury								
he attending physician Mental Hygiene prior to jury, or other traun	CERTIFI	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST d.								
음호를	7	PART II. Other algnificant condition	s contributing to death bu	it not resulting in	the underlying cer	use given in Part i	. 24a. WAS AN A PERFORM	NEO?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
inficate has been signed by State Dept. of Health and or Item 23 shows any It	N: MEDIC								1 YES 2 NO	
State During	rsician:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? YES 2 \(\text{NO} \) NO	HOSPITAL: 1 Inpatient 2 ER/Outpa		26. PLACE DTHER: Nursing Home 5	OF DEATH (Check onl				
N	ву рну	27. MANNER OF DEATH Natural 5 Pending 2 Accident Investigation	28a. DATE DF INJURY (Month, Day, Year)	28b. TIME (OEŞCRIBE HOW IN	JURY OCCURED		
	ETED E	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Special	At home, farm, stre	set, factory, office		OCATION (Street sn Dity or Town, State)	d Number or Rui	rel Route Number,	
FUNERAL DIRI within 72 hour TANT: If Item	COMPLE		CIAN: To the best of my knowle R: On the basis of examination						se(s) and manner as stated.	
TO THE FUNER be filed within IMPORTANT:	B	29b. SIGNATURE AND TITLE OF CERTIFIER	no Cen	ne	29c	LICENSE NUMBER	-cg	29d. DATE SIGN	IEO (Month, Day, Year)	
FAR	5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF OEA		ini) 828	- w s	caus	Ser	Acre ho	
21		31. DATE FILED (Month, Day, Year) MAR 19 102	32. REGISTRAR'S SIGNA							



BALTIMORE, MARYLAND 21215-0020	SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	te medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO SELECTIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2	THE BLACEMAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shouls in man within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	INFORTANT. II item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OF STREET, THE PROPERTY THE Last Street Stre
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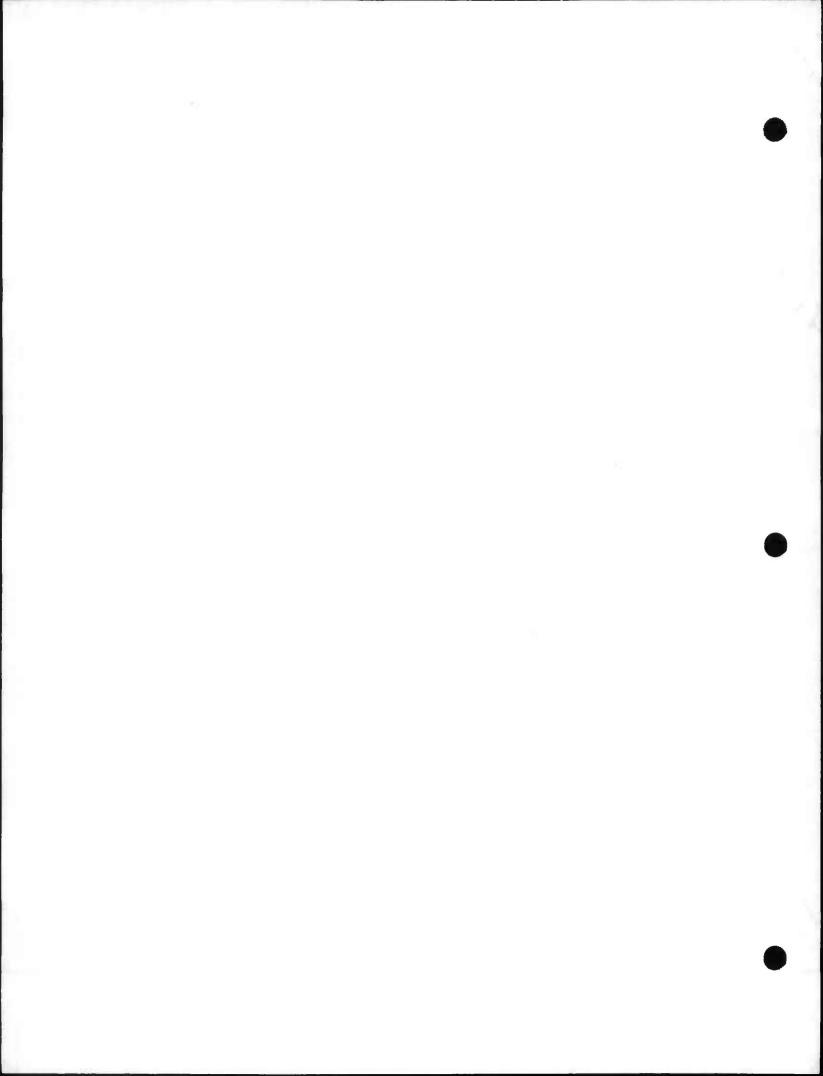
	1 - STATE REGISTRAR	STATE OF MARY	(LAND / DEPART CERTIFIC	MENT OF H			GIENE G. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEA		3. TIME OF DEATH D
		SEPH SMITH,	JR.				11 1993	5:30 M
	4. SOCIAL SECURITY NUMBER		E (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIR (Month, Day,)	bar)	BIRTHPLACE (State or Foreign Country)
	516-80-5839	1 € M 2 □ F	21 YRS.			JUL 5		ILLINOIS
œ	Sa. FACILITY NAME (If not institution, give				R LOCATION OF DE	ATH		Y OF DEATH
DIRECTOR	NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGON							GOMERY
RE	10a. STATE 10b. COUNT	Y	10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?
	ILLINOIS COO	K		PARK FO				1 YES 2 NO
RAL	10e. STREET AND NUMBER			101.	ZIP CODE			N OF WHAT COUNTRY?
FUNERAL	289 JUNIPER STRE	ET 12. WAS DECEDENT EVER	D IN 11 0 ADMED	40 990 050	60466 ENGENT OF HISPAN	10 0010410 m		TED STATES
	1 X Never Married 2 Married	FORCES? 1 V YE		If yes, spe	city Cuban, Mexica 24 NO Specify	n, Puerto Rican, e		I. RACE — American Indian, Black, White, etc.
ВУ	3 Widowed 4 Divorced	1991 - F		' '	a-Ej No Specin			Specify: WHITE
COMPLETED	15. DECEOENT'S EDU (Specify only highest grad	JCATION le completed)	16a. DECEDENT'S U (Give kind of wo	ork done during mos	N st of working	16b. KINO	OF BUSINESS/INDUS	STRY
JE	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use			DET	PENCE	
W	1 2 17. FATHER'S NAME (First, Middle, Last)		U.S.N.	AVI	18. MOTHER'S NA		FENSE	
	PAUL JOSE	ри смтти					OREEN HOT	ירשעדככ
BE	19a. INFORMANT'S NAME (Type/Print)	III OHIIII	19b. MAILING /	ODRESS (Street ar			or Town, State, Zip Co	
2	FRANK SMITH		SAN	Æ AS	ITEM #1	.0		
	20s. METHOD OF DISPOSITION	novel from State	tob. PLACE AND DATE Of cemetary, crematory or oth		me of	DATE 2	0c. LOCATION — Cit	y or Town, State
	1 M Burial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)		HARLOWTON	CEMEI		3/20	HARLO	WTON. MT.
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	. 62	22. NAME AN	D ADDRESS OF FA	CILITY		
	11/11/11	rameen	M00091	L W. W.	CHAMBER	s co.,	RIVERDAL	E, MD. 20737
	23. PART I. Enter the diseases, or ahock, or heart fellure.	compilcations that cause on List only one cause on	sed the death. Do no seach line.	ot enter the mod	de of dying, suci	h as cardiac or	respiratory arres	t, Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition							Onset and Death
	resulting in death)		C ENCEPHA					
7			0 × 0011020021102 01 /	•				i
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE OF)	:				
2	cause. Enter UNDERLYING CAUSE (Disease or injury	c						
Ë	that initiated events resulting in death) LAST	DUE TO (OR AS	S A CONSEQUENCE OF)	:				i i
빙	7	d						
A P	PART II. Other significant condition	ns contributing to death	but not resulting in	the underlying	cause given in	Part I. 24a. W	AS AN AUTOPSY ERFORMED?	24b. WERE AUTOPSY FINDINGS AMULABLE PRIOR TO
음			_				YES 2 NO	COMPLETION DF CAUSE OF DEATH?
M						_		1 TES 2 NO
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	1		26 Bt	ACE OF OEATH (Ch	at ast ass)		<u> </u>
SC	25. WAS CASE REFERRED TO MEDICAL EXAMINER? CLEARED B	4 (7) 4 -41 4 6 /		OTHER:				
HX	27. MANNER OF DEATH	26a. DATE OF INJUR	ry 28b, TIME	OF 28c, INJU	S Residence		HOW INJURY OCCU	REO
ВУР	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year	r) INJŪ		RK? ES 2 NO			
	3 Suicide 6 Could not be	28e. PLACE OF INJU building, etc. (S	IRY — At home, tarm, at pecify)	reet, factory, office		28f. LOCATION (City or Town	Street and Number or , State)	Rural Route Number,
COMPLETED	4 Homicide determined					_		
뒫	one)	SICIAN: To the best of my kn						
Ö	2 MEDICAL EXAMIN	1	tion and/or investigation	, in my opinion, de	eath occured at the	time, data and pla	ace, and due to the	cause(s) and manner as stated.
BE	SHE SIGNATURE AND TITUE OF CHRISTIES	2. (V)	MA		29c LICENSE NUN		29d. DATE S	SIGNED (Month, Day, Year)
2	MANUE AND ADDRESS OF PERSON WI	HO COMPLETED CALLES OF	DEATH (ITEM OF CO.	Brint)	D-43443		7 5	112143
	JOHN CHANDLER,		Senin (HEM 27) (1ype, 1	(HR)	NATIOI BETHES	NAL NAVA SDA, MD	AL MEDICA 20889-56	L CENTER
	31. DATE FILED (Month, Day, Year)		GNATURE			,		
	MAR 18 '93	Suria Das	GNATURE Advidas	2				



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BALLIMORE, MARTLAND 21215-0020	SICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	n, or removal.	e medical examiner must be notified at once.	
Chiston of VII AE RECORDS, F.O. BOX 88760,	TO THE HISPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2	TO THE HURSAL DISCOR, After this certificate has been signed by the attending physician and completely i	be filed with 72 per after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT TIME 28 Is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

							9:	3 (18946
	1 - STATE OF MARYLAN	D / DEPAR	TMENT OF	HEALTH AND F DEATH	MENTAL	HYGIEN REG. NO.			
7	1. DECEDENT'S NAME (First, Middle, Last) JOHN W.SM				2. DATE O	F DEATH DA	W.	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In y	rs. lest birthdey)	IF UNDER 1 YEAR		Mar.		199		PLACE (State or Foreign
	212-18-5191 XXM 2 G F 74	4 YRS.	MONTHS DAY	N OR LOCATION OF D	05-0	3-19		Ma	ryland
e o	Suburban Hospital			thesda	EATH		MONI		MERY
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR LO				111021	<u> </u>	10d, INSIDE CITY
PE	Maryland Montgomery	2		Spring					LIMITS? 1 YES 2 NO
BY FUNERAL	13920 Castle Blvd, #610			101. ZIP CODE 209(04		10g. CITI2		S.A.
FUN	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U. 1 □ Never Married 2 ☑ Married FORCES? 1 □ YES	ONKINO		ECENDENT OF HISPA specify Cuban, Mexico			or No-	14. RACE Black	— American Indian,
	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATE:	S		ES 2 NO Specif				Specif	^b Black
COMPLETED	(Specify only highest grade completed)	(Give kind of a	work done during	TION most of working	16b. K	UND OF BUS	SINESS/INDI	USTRY	
MPL	Elementary/Secondary (0-12) Coffege (1-4 or 5+) 5th	Truc	k Dri	ver					
	17. FATHER'S NAME (First, Middle, Last) Walter Smith			18. MOTHER'S NA	we (First, Mic line				
TO BE	19a, INFORMANT'S NAME (Type/Print)	19b, MAILING	ADDRESS (Street	t and Number or Rural	Route Number	City or Town	n, State, Zip	Code)	20904
-	Frances J. Smith (wife)	1392			d, #6	_	Silv		Spring, MD
1			ther place) 1 Memo	rial Par	rk3/2	3 Ro	ckvi	lle	, MD
	21. SIGNATURE AN FUNERAL SERVICE LICENSEE	Don	/ SNO	AND ADDRESS OF FA	VERAL	HOM	E, P	.A.	
	23. PART I. Enter the displaces, Dr complications that caused th	e death Do c		KVILLE,				1	1 Acceptance
	shock, or heart failure. List only one cause on each	ine.				ic or reap	ratory arre	rat,	Approximate Interval Between Onset and Death
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	raff	y D	theat					
z	DUE TO JOSES A CO)	71:						yes
CERTIFICATION	Sequentially illat conditions, if any, leading to immediate cause. Enter UNDERLYING	NEW QUENCE OF	F):						
TIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST	INSEQUENCE OF	F):						
E	d								
MEDICAL	PART II. Other aignificant conditions contributing to death but	not resulting i	In the underly	ing cause given in		4s. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
MED						YES 2	NO		OF DEATH?
	25. WAS CASE REFERRED TO MEDICAL								
PHYSICIAN:	EXAMINERY 1 VES 2 NO NOSPITAL: 1 Inpetient 2 ER/Outpetle	mt 3 🗆 DOA	OTHER:	PLACE OF DEATH (Cr.		Specify)			
	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c.	NJURY AT WORK?			NJURY OCC	URED	
D BY	2 Accident Investigation 3 Suicide 8 Could not be 28e. PLACE OF INJURY — hulldfine ate (Specific)	At home, ferm, a		YES 2 NO	28f. LOCAT	ION (Street I	and Number	or Rural R	loute Number,
ETE	4 Homicide determined				City or	Town, State)			
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge one) 2 MEDICAL EXAMINER: On the basis of examination and								and manner as stated
ш	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU		, parce, es			(Month, Day, Year)
TO B	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	ATEM 27 (To	Out and 1	D176	15		▶ 3	117	193
	Carol L. Bender M.D 115			getown	Rđ. F	locks:	7ille	, 1v	
	31. DATE FILED (MONTH, Day, You) MAR 19 93 32. REGISTRAR'S SIGNATU Julia Davidson	RE		, CONII .		CONV			
	JO JOHN CHARLOW	-Mastar C	ido						



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use as the burial-transit permit, Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital on TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury

4 Homicide

										9	3	08947	
	1 - FOR STATE REGISTRAR	STATE OF MA		DEPAR					MENTAL HYGIEN REG. NO	_			
Į.	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH		YEAR	3. TIME OF DEATH	
	MONICA	В		SLOA	T				March 5.	_ 199		3:45	м
	4. SOCIAL SECURITY NUMBER		arriad (mytot rest swinday) w one			DAYS	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or F Country)		ign
- 6	078 26 9390	1 🗌 M 2 🖾 🛣	88	YRS.	months.	DATE	HOURS	MITTO.	Nov. 19 1	904		V York	
. 4	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY	, TOWN	R LOCATIO	ON OF DE	ATH	9c. COU	INTY OF D	DEATH	
5	Doctors Communi	ty Hospita	a1]	Lanh	am			Pr	ince	George's	3
DIRECTO	10a. STATE 10b. COUNT	ry		10c, C/7	Y. TOWN C	OR LOCAT	ION					10d. INSIDE CITY	
=	Maryland Mont	gomery		100	ilver		126.					LIMITS?	•
	10e. STREET AND NUMBER						ZIP CODE		·	10g. CIT	XX YES 2 NO		
EHAL	11357 Columbia	Pike					209	04				States	
2	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1			13.	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RAC						E — American Indian	
2	1 Never Married 2 Married 3 XWildowed 4 Divorced No						2 XNO	Specify			Spec		
3	15. DECEDENT'S EDI (Specify only highest grad	UCATION		ECEDENT'S				_	16b. KIND OF BUS	SINESS/IN	DUSTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5 +)		le. Do NOT u	se retired.)	ne retired.)							
		2		Homal	cer	er Homemaker Own Home							
200	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NA	ME (First, Middle, Maiden	Sumame)			
N N	John Brockmeyer								Burgess				
5	194. INFORMANT'S NAME (Type/Print) Carl B. Knox		.1						Route Number, City or Tow	n, State, Zi	p Code)		
						_	Pla	ce	Bowie Mo	d	2071	.5	
	20a. METHOD OF DISPOSITION 1XXBurial 2 Cremation 3 Ref	noval from State	cemetery c	ematory or o	ther place)				DATE 20c. LO	CATION —	City or To	own, State	
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE	Fort	Line	coln	Ceme	etery	0.05.51	Bro	entwo	ood l	Maryland	
	D1.15		1		"B	Beal.	L-Eva	ns I	Funeral Ho	me, l	P.A.		
	Robert	. Cuan	2, 1	16	<u>ا</u> ا	6000) Ann	apo]	lis Rd. Bo	wie N	Md. 2	20715	
	23. PART i. Enter the diseases, or shock, or heart failure.	complications that of	caused the c	leath. Do	not enter	the mo	de of dyle	ng, sucl	h as cardiac or reapi	ratory ar	rest,	Approximat	
	IMMEDIATE CAUSE (Fine)	0 .			P	9		_	0		00	Onset and I	
	disease or condition resulting in death)	. Carce	nom	9.	-07		an	Cr	lase	we	th		
		DUE TO (O	R AS A CONS	EOUENCE O	F):	1	1	A	lase st.				
	Sequentially list conditions, if any, leading to immediate	DUE TO (O	AS A CONSI	EQUENCE O	rla Fi:	и	me	Xa	stades				

that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 1 - YES 2 - NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL:
| Impatient 2 | ER/Outpatient 3 | DOA OTHER: 4 Nursing H 1 YES 2 NO ne 5 🗆 Residence 6 🗆 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Accident
2 Accident
3 Suicide 5 Pending Investigation 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)

29e. CERTIFIER
(Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated.
2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. occured at the time, date and place, and due to the cause(e) and manner as stated.

DUE TO (OR AS A CONSEQUENCE OF):

296. SIGNATURE AND TYLE OF CENTIFIES 29d. DATE SIGNED!(Month, Day, Year) 0

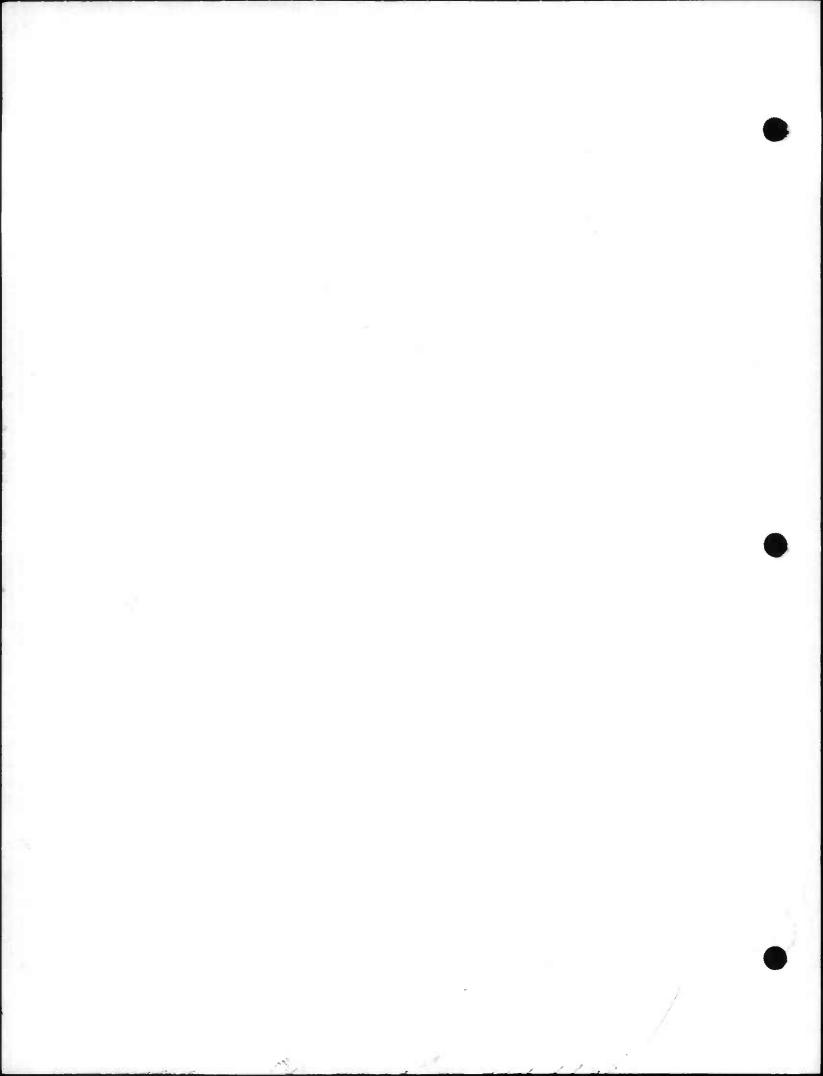
m. CAUSE OF DEATH (ITEM 27) CTYPO, Print) COMPLETED Mitchel 000 20 6

MARU 9 1993

6 Could not be determined

32. REGISTRAR'S SIGNATURE ia vavidson-Randelle

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)



DIMISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPING CRATENIONS PARSICIAN. The law requires that the death conflicate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL RESCRIB AND THE CONTROLL THE PAGE 10 MAY AND THE FUNERAL RESCRIB AND THE PAGE 11 MAY AND THE

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	REGISTRAR		CE	HIIF	ICATE C	F DEATH	P	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last,			-			2. DATE OF	DEATH			3. TIME OF DEATH	
	Catherine	Hazel S	Suit				Month	C DA		YEAR	2.20 [) _M .
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. lesi	t hiphara	IF UNDER 1 YEA	R IF UNDER 24 HRS.	March		1993			
					MONTHS DAY		7. DATE OF I (Month, De	y, Ybar)		Countr		
1	577-10-2186	1 🗆 M 2 💢 F	78	YRS.		100000	05/07	/191	4	Mid	dleburg, \	VA
L. 1	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TOY	N OR LOCATION OF D	EATH		9c. COU	NTY OF D		
18	Fairland Nursing	Home			Silve	er Spring			M	onta	omery	
ECTOR	RESIDENCE OF DECEDENT									Jing	omer y	
m	10e. STATE 10b. COUN	TY		10c. CIT	Y, TOWN OR LO	CATION					10d. INSIDE CITY	
DIR	Maryland Calve	ert		Lu	sby						LIMITS?	
	10s, STREET AND NUMBER				100)	10f. ZIP CODE			40- 017	TTTN OF N	WHAT COUNTRY?	
FUNERAL		bird Drive										
ᄬ						20657			U	.S.A	•	
ا جَ ا	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S. ARI	MEO	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (S	pecify Yes	or No-	14. RACE	- American Indian,	
	1 Never Married 2 Married	IF YES, GIVE WA	A OR DATES		1 🗆	specify Cuban, Mexic (ES 2 X NO Speci	en, Puerto Rica: fy:	1, etc.)		Speci	k, Whits, etc.	
BY	3X Widowed 4 Divorced										White	
	15. DECEDENT'S ED (Specify only highest grad	UCATION	16a. DEC	CEDENT'S	USUAL OCCUP	ATION	16b. KIR	D OF BUS	HNESS/IN	DUSTRY		
iii	Elementary/Secondary (0-12)	College (1-4 or 5+)	lile.	Do NOT us	work done during se retired.)	most of working						
립	12			ecret	arv		He	ivor	city	of A	Maryland	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		1 36		/	18. MOTHER'S NA				OI N	iai yiailu	
	Programme and the second secon								,			
8	Dillian Trenary						Mae (
2	19a. INFORMANT'S NAME (Type/Print)					et and Number or Rural						
F	Charles A. Suit		8.	15 B	lack D	uck Drive	. Port	Ora	nge	. FI	32127	
1	20e. METHOD OF DISPOSITION 1X Burlal 2 Cremation 3 Rec		20h PLACEA	NDDATE	OF DISPOSITION	(Name of	DATE	200 100	CATHON	City or To	um Ctata	
	1X Buriel 2 Cremetion 3 Rei	moval from State	cemetery, crer	matory or o	ther placa)		10 100	D			Marylan	
	21. SIGNATURE OF FUNERAL SERVICE L	IOTHOSE .	Fort	Linc	oin Ce	metery 3	/9/93	Br	entw	<u>/ood</u> ,	Marylan	<u>d_</u>
1 1	21. SIGNALUNE OF FUNERAL SERVICE L	CENSEE		1	Eran	cis Gasch	CODE	Fur	20201	Цот	D A	
	1 One la	1) 7										
	22 PART I Fater the diseases on		no.	-3	4/39	Baltimor	e Ave.	нуат	tsvi	llle,	MD 20781	
	23. PART I Enter the diseases, or shock, or heart fellure	List only one ceus	caused the de-	ath. Do r	not enter the	mode of dyling, suc	ch as cardiac	or respi	ratory an	rest,	Approximate interval Between	
	IMMEDIATE CAUSE (Final	O	#CI 00-54		-	. /					Onset and De	
	disease or condition resulting in death)	· Krik	1100	ve-	Fe	lune					1	
	resulting in death)	DUE TO I	OR AS A CONSEC	DUENCE OF	F):						1	_
- 1	_	/2	on as a consecuted	/	10000	1					1	1
CERTIFICATION	Sequentially list conditions,	b. Gode to d	OR AS A CONSEC			7/					-	
F	if any, leading to immediate cause. Enter UNDERLYING	10.	/	1	. 4	700.00					i	
2	CAUSE (Disease or Injury	· JEM	u 6	Jen	ren							
	that initiated events resulting in death) LAST	DUE TO (C	OR AS A CONSEC	IUENCE OF	F):							
#	resulting in death) LAST	d										- 1
Ö												- 55
EDICAL	PART ii. Other significant condition	ns contributing to d	leath but not n	esulting	In the underl	ing cause given in	Part I. 24	PERFOR		24b	WERE AUTOPSY FINDIN	NGS
할											AMAILABLE PRIOR TO COMPLETION OF CAUS	SE.
							— ''	YES 2	C NO	- 1	OF DEATH?	
Σ							_				1 YES 2 NO	
PHYSICIAN:												
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					PLACE OF DEATH (C	heck only one)					
Š	1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:	lome 5 - Residence	6 Other (%	ecffv1				
È	27. MANNER OF DEATH	26s. DATE OF II	NJURY	28b. TIM	E OF 28c.	INJURY AT	28d, DESCRI		NJURY OC	CURED		$\overline{}$
	19 Netural 5 Pending	(Month, Day	(Year)		URY	WORK?	200.0000	DE 11011 11		CONLD		
B≺	2 Accident Investigation					YES 2 NO						
8	3 Suicide 8 Could not be	25a. PLACE OF building, a	INJURY — At hor tc. (Specify)	me, ferm, s	street, factory, o	ffice	281, LOCATIO	N (Street a wn, State)	nd Number	or Rural F	loute Number,	
	4 Homicide determined											
COMPLET	29a. CERTIFIER	SICIAN: To the best of m	w knowledge des	ath occurre	ad at the time	eta and etana and du						\neg
불												
8	one) 2 MEOICAL EXAMIN	En. On the bests of the	Immatron snezor ii	INVESTIGATIO	п, іп ту оріпю	n, death occured at the	time, dats and	place, and	d due to ti	ne cause(s) and manner as stated	d.
ш	296. SIGNATURE AND JUTE OF CERTIFIE	EPY				29c. LICENSE NU	MBER		29d. DAT	E SIGNEO	(Month, Day, Year)	
ω	1 word					N24'	772				1-93	
2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CALLES	OF DEATH OTEN	1 271 /5	Print)	DOT	AHANIBM -	11 0		- 0		
	1.62		· · · PENIL (IIE	- 41) (1)/DB,	einnj	VICKE	N POOCHU		n			
	/ MAR 0 8 1001	Sa. K		-		563	ANNAPOL	SROAL	1			
1	THE DATE PLES (MONTH, Day, 1647) 33	32.41ESIS 111AH	"S GROWN ATOMEST	locator.		LADENS	BURG, MD.	20710-	2268			
1		۲					779-760	7				- 1

1 - STATE

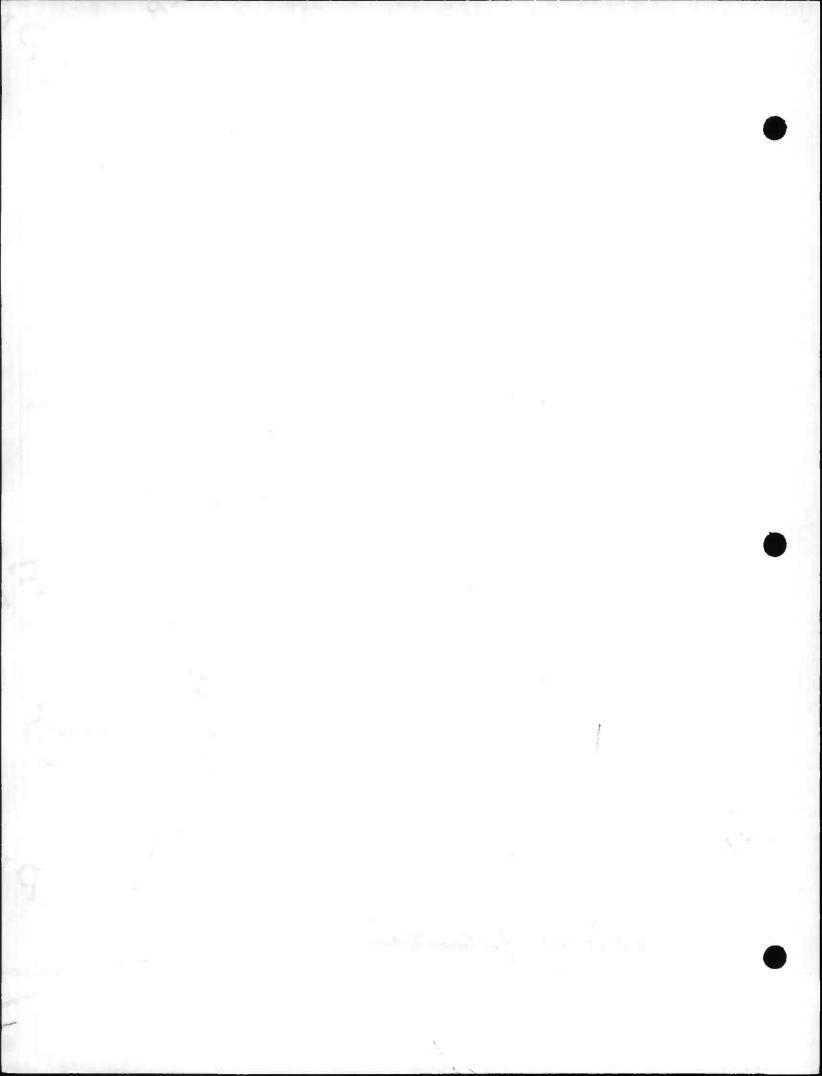
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		CENTIL	CATE OF	DEATH	REG. NO		
1	1. DECEDENT'S NAME (First, Middle, Lest) Mary	М.	Stampfer			2. DATE OF DEATH MONTH 5, I	* 993 *	3. TIME OF DEATH 12:45 A. M
			yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign
	311 07 7711	1□M2\F 46		MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 12-8-194	6 1	Vashington, DC
or.	9a. FACILITY NAME (If not institution, give stre				OR LOCATION OF DE	EATH	9c. COUNTY	
9	Physicians Memori	al Hospital		LaP1a	ita		Char	les
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCA	TION			10d. INSIDE CITY
=	Maryland Ch	arles		Waldo	rf			1 YES 2 NO
A	10e. STREET AND NUMBER				N. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	2010 Amber Leaf Pl	ace			20602			USA
5		12. WAS DECEDENT EVER IN I	J.S. ARMED	13. WAS DE	CENDENT OF NISPAN	IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	or No- 14	RACE — American Indian, Black, White, etc.
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DAT	ES		S 2 NO Specifi			Specify: White
TED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION (mpleted)	(Give kind of w	ork done during m	ON ost of working	16b. KIND OF BU	SINESS/INDUS	TRY
Ü	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)				
COMPLETE	10th		Hot	ısewife	T			Home
-	17. FATHER'S NAME (First, Middle, Last)	D 1			18. MOTHER'S NA	ME (First, Middle, Maiden		
	Harry J.	Beckert	405 MAH ING	400000000000000000000000000000000000000	1000	Dorothy		
TO B	THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, THE PERSON NAMED IN COLUMN TWO IS NOT THE OWNER, T					Route Number, City or Tow		
	Stephen M. Stampf		LACEAND DATEO			Waldorf		0602 or Town, State
	1 Burial 2 Cremation 3 Remov		ery cremetory or off	ner nlace)	netery 3			
	21. SIGNATURE OF FUNERAL SERVICE LICE		· vetera	22 NAME A	ND ADDRESS OF EA	CHITY		m, Maryland
	* George	Kales	10 ==			las Funera 11 Rd. Oxo		. Md. 20745
	23. PART I. Enter the diseases, or co	mplications that caused t	the death. Do n					, Approximate
	shock, or heart failure. Li iMMEDIATE CAUSE (Final	at only one cause on aac	th lina.					Onset and Death
	disease or condition resulting in death) a.	Cardiac	Arrest					
	a.	DUE TO (OR AS A C	ONSEQUENCE OF);				
Z	Sequentially list conditions, b.		of the I					
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A C	ONSEQUENCE OF):				
길	CAUSE (Disease or Injury C.	DUE TO (OR AS A C	ONSEQUENCE OF	١٠				
E	that initiated events resulting in death) LAST	-32 12 (0.11.011		,•				i
	d.							
AL C	PART II. Other significant conditions		not reaulting in	the undarlyin	g cause given in	Part i. 24e. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
: MEDICAL	Arteri	osclerosis				1 YES 2		COMPLETION OF CAUSE OF DEATH?
ME								1 - YES 2 - NO
ä								
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. P	LACE OF DEATH (Ch	eck only one)		
ΥS		inpetient 2 XER/Outpet	lent 3 DOA	4 - Nursing Hor	ne 5 🗆 Residence			
РНУ	27. MANNER OF DEATH 1 X Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME	JRY W	JURY AT ORK?	28d. DESCRIBE HOW I	NJURY OCCUR	ED
BY P	2 Accident Investigation	20- 54 405 05 14 1150	445 - 4		YES 2 NO			
ETED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify	- At nome, term, st	reet, factory, offic	•	28f, LOCATION (Street City or Town, State)	and Number or i	Rural Route Number,
	29a. CERTIFIER			o control to a	popular A77)			
COMPL	(Check only	AN: To the best of my knowled						
8		On the begin of aximination (navor investigation	, in my opinion, (ause(a) and menner as stated.
ш	286. SIGNATURE AND TITLE-BE CERTIFIED	11/2	-		29c. LICENSE NUM	IBER		GNED (Month, Day, Year)
m	70-7	X / Cerro			1		Marc	h 5, 1993
0 8	20 MANE AND ADDRESS OF SERVICE	DOMESTIC CONTRACTOR	an demonstration					
TO B	30. NAME AND ADDRESS OF PERSON WHO				CFU	-1-4	D.C. C	
	30. NAME AND ADDRESS OF PERSON WHO Eduardo R. Ilano 31. DATE FILEDWAR (19. 18.) 1993	, M.D. 132	8 Southe	ern Ave	,S.E. Wa	shington,	D.C. 2	

BALTIMORE, MARYLAND 21215-0020

WSION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-16 Rev 1/89



1 -

DIRECTOR

FUNERAL

BY

COMPLETED

2

MEDICAL CERTIFICATION

PHYSICIAN:

BE COMPLETED BY

2

4 Homicide

H BE notified

IR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the ho	TO HE HIME ALL INFECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detact		MPORTANT: Il lism 28 is merked, or item 23 shows eny injury, or other traumatic event, the medicel examiner must be notified at once	
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7 24	N T	ation	ŧ	
withi	piete	In the state of the state death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ent,	
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											93	0	8950	
FOR STATE REGISTRAR	STATE OF I	MARYL			TMENT					HYGIEN	E			
1. DECEDENT'S NAME (First, Middle, Lest)									2. DATE OF	DEATH			3. TIME OF DEA	ТН
LILLIE SANTA	SHIPLEY								03/0	9/19		YEAR	7:47	Ам
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE ('In yrs. lest	birthday)	IF UNDER	DER 1 YEAR IF UNDER 24 HRS.			7. DATE OF BIRTH			8. BIRTHPLACE (State or Foreign		
220-38-0913	1 🗆 M 2 💢 F		78	YRS.	MONTHS	DAYS	MYS HOURS MIN. (Month, Day, Year) 12/01/19			1/19	14 Dickerson, MD			
9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH														
6126 54th Avenu	ıe				Riv	erd	ale				Prir	ice (George's	
10a. STATE 10b. COUNT	Υ			10c. CIT	Y, TOWN O	R LOCAT	TION	_					10d. INSIDE CIT	,
Maryland Princ	e George	1 _S			erda								LIMITS?	
10e. STREET AND NUMBER	<u> </u>				0. 00	_	. ZIP COD	E			10a. CIT	IZEN OF	WHAT COUNTRY?	
6126 54th Avenu	ie						2073	7				U.S.A.		
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				MED O	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 — YES 2 No Specify: White									
15. DECEDENT'S EDU (Specify only highest grade			16a. DEC	EDENT'S	USUAL OC	CUPATIO	ON ast of worldi	10	16b, KJ	ND OF BUS	HNESS/IN	DUSTRY		
Elementary/Secondary (0-12)	College (1-4 or 5	+)			work done during most of working ea retired.)									
7			Hc	use	wife				<u>Ow</u>	n Ho	me			
17. FATHER'S NAME (First, Middle, Last)									ME (First, Midd		Surname)			
James C. Jarbos	<u> </u>						Ro	ose	E. St∈	elle				
19a. INFORMANT'S NAME (Type/Print)			19b	. MAILING	ADORESS	(Street e	nd Number	or Rural I	Route Number,	City or Town	n, State, Zi	p Code)		
Andrew M. Ship	ley			6126	54th	A	enu-	e, R	liverd	ale,	Mary	/lanc	20737	
20a. METHOD OF DISPOSITION 1 V Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	ioval from State	20b	PLACE A petary, cren Ort	ND DATE	of DISPOS ther place)	TION (NE	etery	/ 3	OATE / 12/93	20c. LO	entv	city or To	own, State , Maryla	and
1						.A.								
23. PART I. Enter the diseases, or shock, or heart failure.	compilcations the List only one car	t caused use on a	the dea	ith. Do i	not enter	the mo	de of dy	ing, suci	h aa cardiad	or reapi	ratory ar	теаt,	Approxim	etween
IMMÉDIATE CAUSE (Final disease or condition resulting in death)	. CAI	1012	Inu	14	OF	G	ALL	B2	A Phs	R			Onset an	
resouring in Death)	DUE TO	(OR AS A	CONSEQ	UENCE D	P):			17						
Sequantially flat conditions, if any, leading to immediate cause. Enter UNDERLYING	b	(OR AS A	CONSEQ	UENCE O	F):									

Sequantially list conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i.

e. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	1 TYES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 TES 2 NO ne 5 Residence 6 🗆 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 M Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be

29e. CERTIFIER (Check only 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

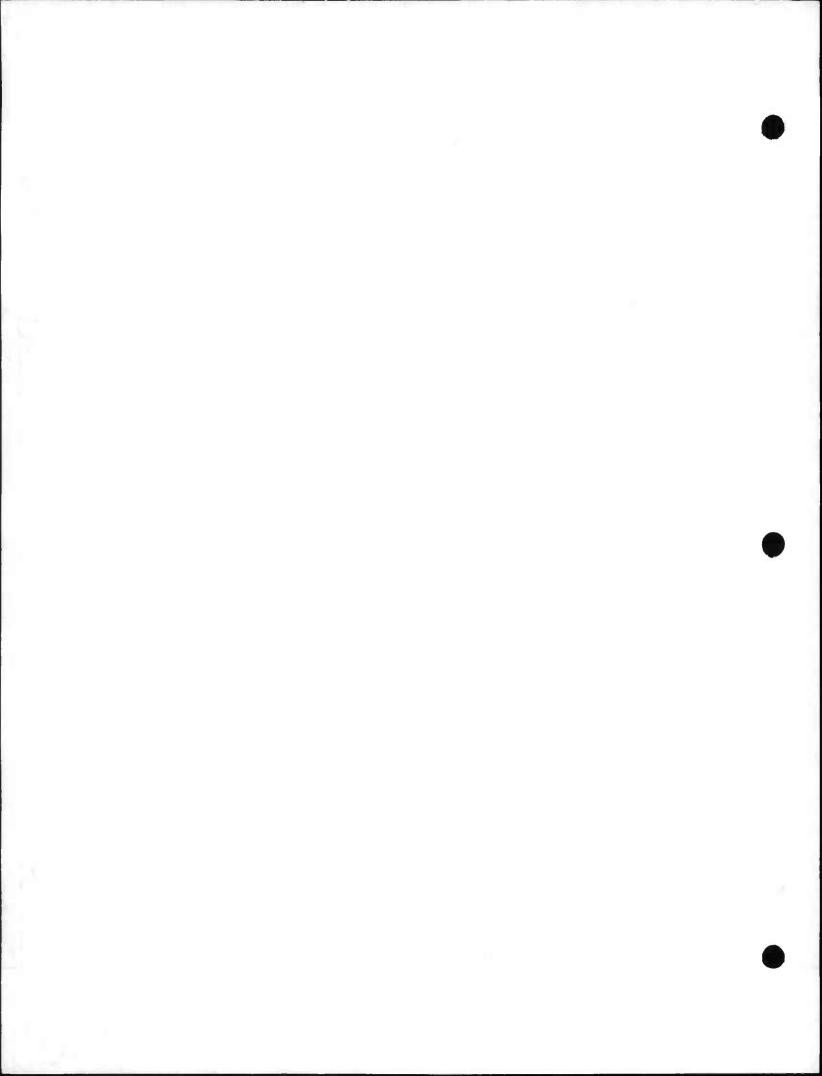
2 MEDICAL EXAMINER: On the basis mination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 3/9/93 ANTON DO 589

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Roger B. Ingram, 6510 Kenilworth Avenue, Riverdale, Maryland 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE MAR 1 2 1993

Lukie Devidson-Randelle



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

MAR 1 0 1993

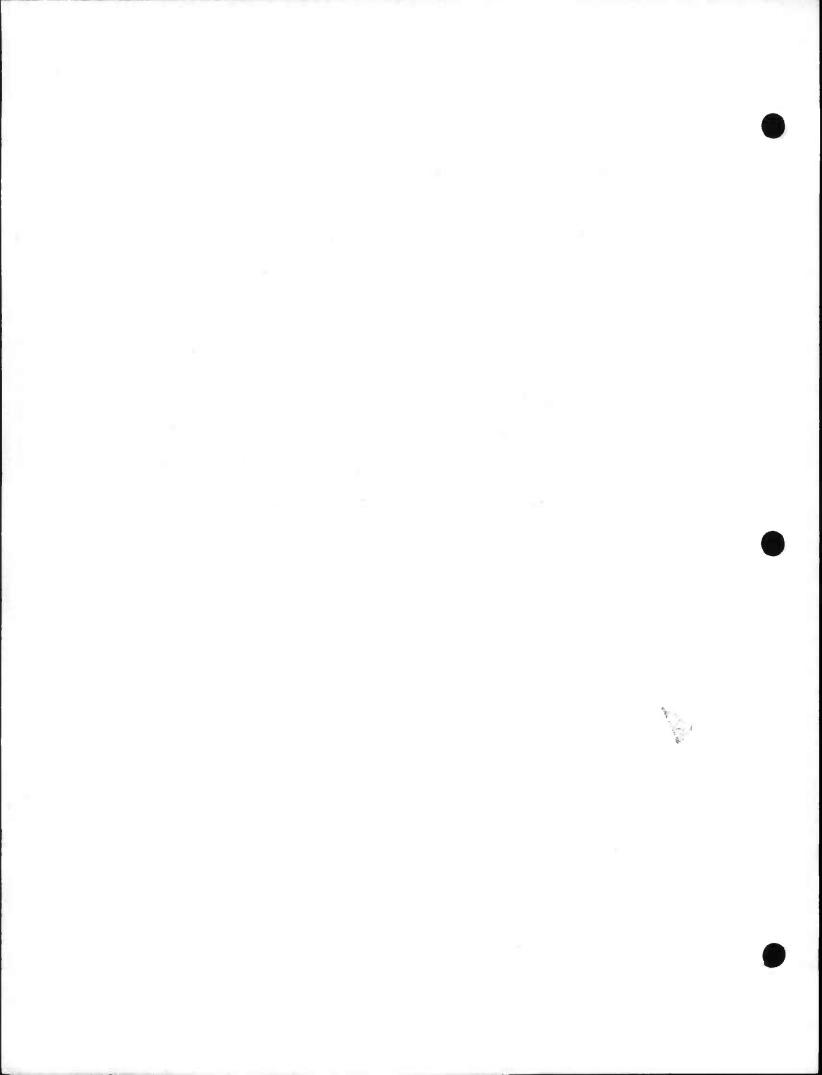
32. REGISTRAR'S SIGNATURE

may be retained by the hospital or attending physician.	; page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should	the constitution of the co
PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	if this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	arted or item 22 chains and lating or other transmission and the modified available and the modified at another
3 PHYSICIAN: The law re	or this certificate has been the with the State Dept. c	sacked or learn 22 at

11. 11.								93	08951
		FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR CERTIF	TMENT	OF HEALTH AND	MENTAL HYGIE		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH	DAY	3. TIME OF DEATH
		DARRELL	J.		SCO'	TT	02	17	93 4:47 Am
				in yrs. last birthday)	IF UNDER 1	YEAR IF UNDER 24 HRS DAYS HOURS MIN.	(Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)
3				33 YRS.			8-01-62		Wash.,D.C.
3 sho	æ	9a. FACILITY NAME (If not institution, give street				OWN OR LOCATION OF	DEATH		TY OF DEATH
. 2,	[유	SOUTHERN MARYL	AND HOSPIT	AL	CL	INTON		PRII	NCE GEORGES
ages	DIRECTOR	10a. STATE 10b. COUNTY			Y, TOWN OR				10d. INSIDE CITY
physician. burial-transit permit. Pages 1, 2, 3 should			Georges'	Te	mple	Hill			1 X YES 2 NO
Thed 1	FUNERAL	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZ	EN OF WHAT COUNTRY?
an. Transi	Ä	2709 Oxon Run Driv				20748			.S.A.
physician burial-tra		11. MARITAL STATUS 1 1 Never Married 2 X Married	2. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	H y	res, specify Cuban, Mex	PANIC ORIGIN? (Specify Y lcan, Puerto Rican, etc.)	es or No —	14. RACE — American Indian, Black, White, etc.
ending p as the b	В	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES	10	TYES 2 X NO Spe	city:	ŀ	Specify: BLACK
r attending use as the	COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co.	TION	16a. DECEDENT'S	USUAL OCC	UPATION	16b. KIND OF B	USINESS/INDI	
			College (1-4 or 5+)	life. Do NOT us	e retired.)	ring most of working			
the hospital or detached for u	MP	12th		Mainten	ance	Tech	Dept. (of Tre	asury
		17. FATHER'S NAME (First, Middle, Last)					NAME (First, Middle, Maide	,	
	BE	Sylvester Scott, 19a. INFORMANT'S NAME (Type/Print)	Sr.				Minor-Sco		
5 should notified	2		44 / 2 C-				al Route Number, City or To		
may be or, page		Alesia Wallace-Sco	20h	PLACE AND DATE			Lane Ft.		MD ZU/44
e 6 mar ector, p		ty Burisi 2 ☐ Cremation 3 ☐ Remova	I from State come	etery, crematory or o	ther place)	Memorial I		andove	
	ij	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE /	at I Hai	22. NA	ME AND ADDRESS OF	FACILITY		
death. Pag e funeral di I. examiner		1 / Mun ()	11	#943			son Funeral		
after by the mova		23. PART I. Enter the diseases, or con	notications that caused	7	ITOO	1 Good Hop	oe Road, S. I	. Was	h.,DC 20020
d in		ahock, or heert feilure. Lis iMMEDIATE CAUSE (Final	it only one ceuse on ee	ch line.	or onto	ie mode or dying, si	JULI SE CEIGIOC OI 166	piletory arre	Approximate interval Between Onset and Death
Pe Pe	1	disease or condition	Gunthe	+ 111	Jun P	al CD.	at and A	blom	Onset and Death
completely fill rial, cremation, c event, the		resulting in death) a	Gunshi DUE TO (OR AS A	CONSEQUENCE OF	7:	- Ca	51000	0000	040
	N	Sequentially list conditions (b.							
th certificate be execute and conding physician and confidence prior to buriate of the traumatic or other traumatic	CERTIFICATION	Sequentially list conditions, If any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	7):				
eath certificate be exattending physician a real Hyglene prior to y, or other traum	15	CAUSE (Disease or Injury	OUE TO (OR AS A	CONSEQUENCE OF	n.				
certification ding Hygier	E	that initiated events reaulting in deeth) LAST	00c 10 (01 A3 A	CONSECUENCE OF					
att att	S	d							
In the	¥	PART ii. Other aignificent conditions of	ontributing to desth bu	it not resulting i	in the unde	erlying ceuse given		N AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
gned by	MEDICAL						N YES	2 🗌 NO	COMPLETION OF CAUSE OF DEATH?
een sign of Healt									1 VES 2 NO
law as t ept ept	SICIAN:	25 MBC CACE REFERENCE TO MEDICAL							
N: The law ficate has be State Dept.	S		IOSPITAL:		OTHER:	26. PLACE OF DEATH (Check only one)		
PHYSICIAN: The this certificate with the State	PHYS	1 TYES 2 NO 1 27. MANNER OF DEATH	26e. DATE OF INJURY	ttlent 3 DOA 28b, TIM	7	g Home 5 - Residenc	e 6 Other (Specify) 28d. DESCRIBE HOW	I IN HIRW OCC	HOED
NG PHYS fter this c eath with marked,	=	1 Netural 5 Pending	(Month, Day, Year)		URY	WORK?			_
After death	8	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY	— At home, farm, s	$\Delta A \perp$	X	SUBJEC 281. LOCATION (Stree		
ATTENDING PHYSICIAN: The COLOR After this certificate his death with the State District In marked, or Item	TED	4 Homicide determined	building, atc. (Specif	W MOTOR I	ODCE		City or Town, Stat	Θ)	
8 6 8	7	29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my knowle			, date and place, and d			MOTOR LODGE
HOSPITAL FLOORING FLO	COMP								couse(a) and manner as stated.
THE HOSPI TO THE F De filed y	S I	296. SIGNATURE AND TITLE OF CERTIFIER	1 1.			29c. LICENSE N			SIGNED (Month, Day, Year)
TO THE TO THE De filed	8	Vermi	4. Chute	nas		O.C.M			/17/93
	5	30. NAME AND AGORESS OF PERSON WHO	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type,	Print)			1.	

111 Penn Street, Baltimore, Maryland

21201



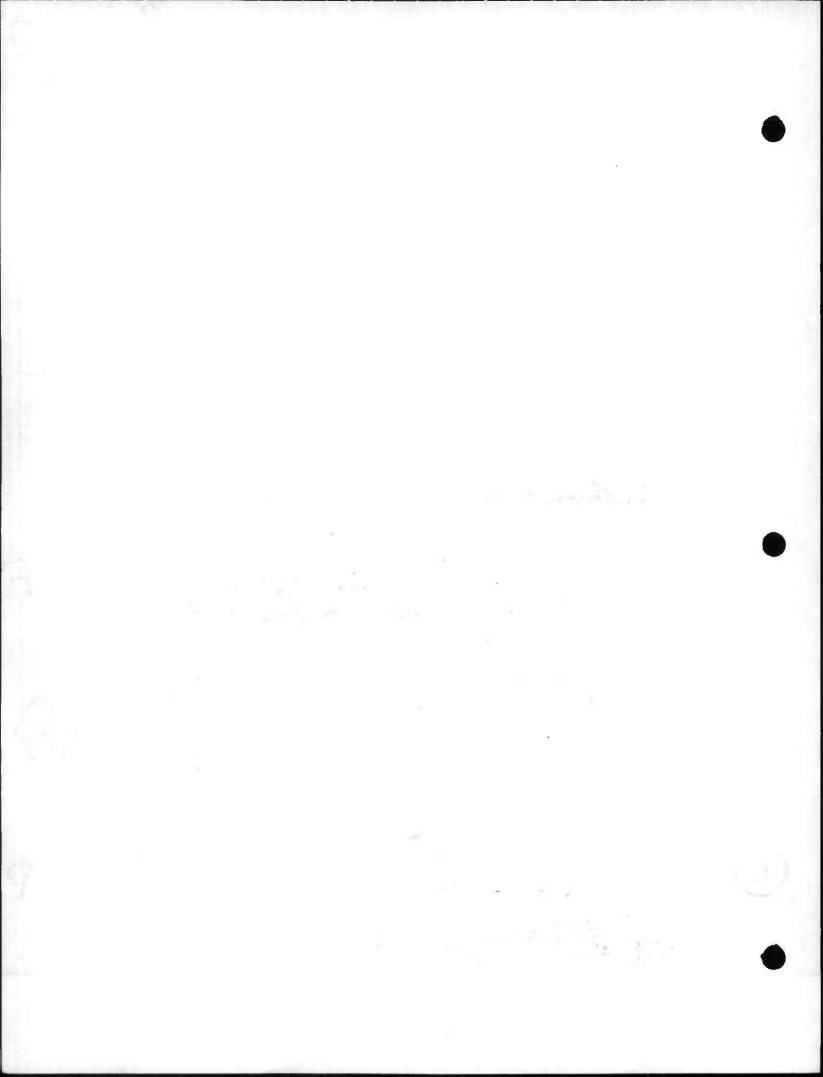
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

OF THENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

UNEFILE DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be the country of Health and Mental Hygiene prior to burial, cremation, or removal.

NIT. If Item 28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFICA			MENTAL HYGIEN		
- 6	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	ANDREW 4. SOCIAL SECURITY NUMBER		ADE, Jr.			03 0	8	93 10:30A M
		5. SEX 6. AGE (I	MON	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not institution, give street	41	00	CITY TOWN O	R LOCATION OF D	Feb. 28, 1		Washington, DC
	PRINCE GEORGE'S H	OSPITAL CEN	TER	CHEV	ERLY	LAIN	PRIN	ICE GEORGE
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY							
DIRECTOR		G 1	377	WN OR LOCAT	ION			10d. INSIDE CITY LIMITS?
	Maryland Prince 100. STREET AND NUMBER	George's	нуаст:	sville	ZIP CODE		10a CITIZE	1 TYES 2XX NO
FUNERAL	4909 55TH Avenue				20781			ed States
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DECI	ENDENT OF HISPA	NIC ORIGIN? (Specify Ye		4. RACE — American Indian, Black, White, etc.
BY F	1 Never Married 2 XXMarried 3 Widowed 4 Divorced	FORCES? XX YES	Z _ NO	1 T YES		nn, Puerto Rican, etc.) y:		Specify:
	15. DECEDENT'S EDUCA	1946-1947	16a. DECEDENT'S USU.	AL OCCUPATIO	A)	16b, KIND OF BU	I CANESCO IN IOU	White
ETE	(Specify only highest grade co	College (1-4 or 5+)	(Give kind of work of life. Do NOT use reti	done during mos ired.)	at of working	160. KIND OF BO	SINESS/INDU	SINT
AP.	12		Mechanic			N.A.S.A	۸.	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	AME (First, Middle, Malder	Surname)	
BE	Andrew Charles Sch	ade, Sr.				Mahoney		
0	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tov		,
	Kathleen Schade	20h	PLACE AND DATE OF DI			Sville, Ma		d 20781
	20s, METHOD OF DISPOSITION XX Buriel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	al from State ceme	etery, crematory or other port Lincoli	n Ceme	terv 3/			, Maryland
- 9	21. SIGNATURE OF FUNERAL SERVICE LICEN			22. NAME AN	O AOORESS OF FA	CILITY		
	1. baron	dyn				Funeral Hourg Road,		
	23. PART i. Enter the diseases, or con shock, or heart failure. Lie	mplications that caused	tha death. Do not a	inter tha mod	da of dyling, suc	th as cardiac or resp	lretory srret	st, Approximate
	IMMEDIATE CAUSE (Final	at only one cause on as	ich line.	1				Intarval Between Onset and Death
	disease or condition resulting in death) s.	Cont	IOI OF	alson,	1			
			CONSEQUENCE OF):		200	1000.		
S S	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS A	CONSEQUENCE OF	JEM!	d or	THE THE		
B	cause. Enter UNDERLYING CAUSE (Disease or injury	13014	Lorge	CP	Book	GROND	LIT	
플	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):		C 11 A	31.0		
CERTIFICATION	d	1119	SIDREIN.	11	240	6 K		
AL	PART II. Other significant conditions	contributing to deeth be	ut not resulting in th	e underlying	ceuse given in	Part i. 24a. WAS AP		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC	25	1217	1102			1 YES :	2 NO	COMPLETION OF CAUSE OF DEATH?
	- ALIE II	it this	MICE			_		1 - YES 2 - NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			26 81	ACE OF DEATH (C)			
SICI	EXAMINER?	HOSPITAL:		HER:				
H	27. MANNER OF DEATH	26a. DATE OF INJURY	28b. TIME OF	28c. INJU	JRY AT	6 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCU	RED
ВУР	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	M 1 Y	RK? ES 2 NO			
	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Speci	— At home, farm, street	t, factory, office		281. LOCATION (Street City or Town, State	and Number or	Rural Route Number,
ETED	4 Homicide determined					100, -1 100		
COMPL		AN: To the best of my knowl						
8	2 MEDICAL EXAMINER	paste of examination	and/or investigation, in	my opinion, de				cause(s) and manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	ILLA M	0		29c. LICENSE NU	MBER	N	SIGNEO (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO.	0 13	THYTEM 27) (Type, Print	0			Ma	rch 8, 1993
	Syant	VA						
	MAR 1 0	999 Juli	Devis As	ndell				



3. TIME OF DEATH

DHMH-16 Rev 1/89

2. DATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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Deam.	funeral	
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DILLIN D	COOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direct	
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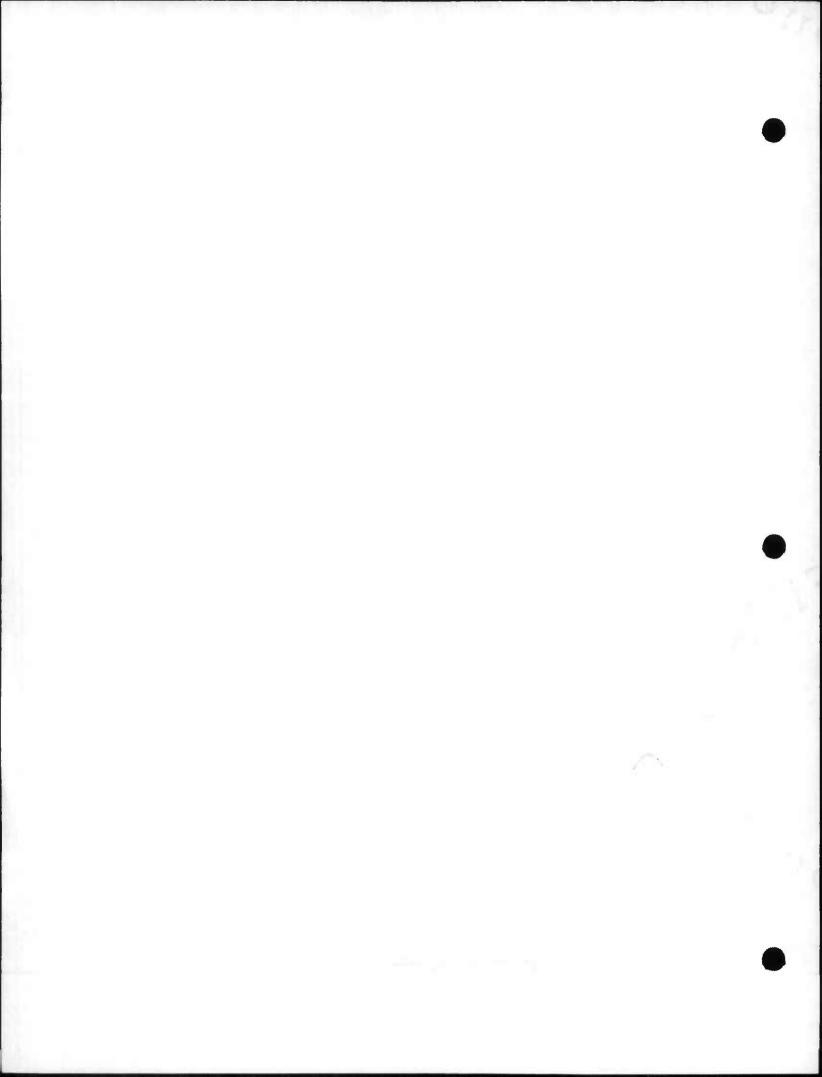
A YEAR SEARS 0905 M Dorothy Perry 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign May 7, 1919 Maryland 214-36-1342 1 🗌 M 2 🔀 F 73 page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Frederick Memorial Hospital Frederick Frederick 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Adamstown Frederick Maryland 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 7303 Ira Sears Road 21710 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Marrie Specify: White 1 TES 2 NO Specify: ΒY 3 Wildowed 4 Divorced COMPLETED 16a, DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refred.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumame) Felix PLUNKARD Cutsail Lorenzo Mamie notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 2121 Wainwright Court, Apt BC, Frederick, MD 21702 Sylvia L. Sears 3 20s. METHOD OF DISPOSITION
1 X Burlat 2 Cremation 3 Removal from State
4 Donation 5 pither (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Stats must 2/26/93 Olivet Cemetery Frederick, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home Ketth 106 East Church St., Frederick, MD 21701 or removal medical 23. PARTA. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate intervai Betwe IMMEDIATE CAUSE (Finel Onset and Death the disease or condition cremation, onel an Ne resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): Mental Hygiene prior to burial, MEDICAL CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Item 23 shows any injury, PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS of Health and AWAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 ☐ YES 2 ☐ NO BY PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) State SPITAL: Inpatient 2 - ER/Outpatient 3 - DOA 1 TYES 2 NO OTHER: ne 5 🗆 Residence 6 🗆 Other (Specify) 4 - Nurs the is marked, or 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED death with 1 Netural Accident 5 Pending 1 YES 2 NO 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) COMPLETED 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be hours after 28 4 Homicide TO THE FINERAL DIRECTOR AT TO THE FINERAL DIRECTOR DE flod within 72 hours a IMPORTANT: If 16m 2 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the basis of sxamination snd/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 52256 WHenry NL 241 2 30. NAME, AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Hen 10 31. DATE FILED (MONTH, Day/No. 32. REGISTRAR'S SIGNATURE 1993

guna vigurara

Rando 00

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



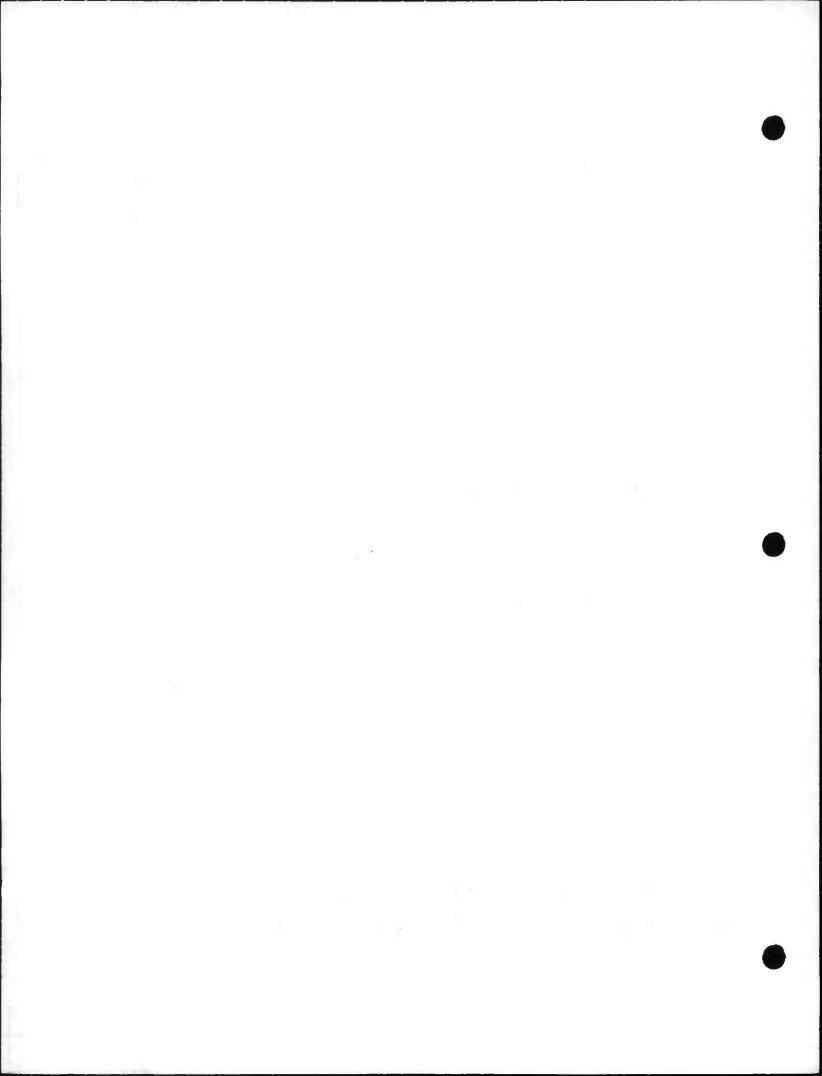
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

HUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

PARIANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	TATE OF MARYLA		MENT OF H		MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Lest) Charlie	Monroe	Stanley	7		2. DATE OF DEATH MONTH MARCH 1	3, 19 ⁸ 5	3. TIME OF DEATH
: ::	A STATE OF THE STA	SEX 6. AGE (II		IF UNDER 1 YEAR HONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 01/12/41	8. BIF	THPLACE (State or Foreign intry)
OR	Pa. FACILITY NAME (If not institution, give street a Dorchester Memo:			ob. City, town Cambi	r LOCATION OF DI	EATH	Dorc	nester
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Markel and Donot	hester	10c. CITY,	TOWN OR LOCAT	Hurlo	alr		10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	-		101	, ZIP CODE			1 YES 2 NO
FUNERAL		WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DEC	2164	SIC ORIGIN? (Specify Years, Puerto Rican, etc.)	U . S or No — 14. R/	A . American Indian, ack, White, etc.
B≺	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES T	1 TYES	2X NO Specif	у:	Sp	ecily: Black
COMPLETED		illege (1-4 or 5+)	(Give kind of we life. Do NOT use Truck I	rk done during mo. retired.)	DN st of working	Consti	ructio	
	9th 17. FATHER'S NAME (First, Middle, Last) Charlie Mon.	roe Stani	l ex			ME (First, Middle, Maiden a Thompso		n l ox
TO BE	190. INFORMANT'S NAME (Type/Print) Glendora C. Sta:		19b. MAILINO A	Railro	nd Number or Rural	Route Number, City or Town ., Hurlo	n, State, Zip Code)	
	20a. METHOD OF DISPOSITION 1	from State 20b.	PLACE AND DATE OF elery, cremetory or other New	DISPOSITION /Na	me of	OATE 20c. LO	CATION — City or	Town, Stata
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSE		ast New		D COM.		st wew	Mkt, MD
	Muhail 7. 8	skm		PO Bo	0x 43,	Federals	ourg,	neral Home MD 21632
	23. PART I. Enter the disesses, or comp shock, or heart failure. List of iMMEDIATE CAUSE (Finsi disesse or condition resulting in death)	only one ceuse on ea	consequence of		Drag		ratory srrest,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS A	CONSEQUENCE OF)					
ERTIFI	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF)					
MEDICAL C	PART II. Other significent conditions con	ntributing to death bu	ut not resulting in	the underlying	ceuse given in	Part I. 24e. WAS AN PERFOR	MED?	4b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
						-		1 TES 2 NO
PHYSICIAN:		SPITAL:		OTHER:	ACE OF DEATH (Ch			
HYS	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	OF 28c. INJ	URY AT	8 ☐ Other (Specify) 28d. DE\$CRIBE HOW II	JURY OCCUREO	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	ULMI		RK? 'ES 2 NO			
<u>a</u>	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Speci	— Al home, farm, str	eet, factory, office		281. LOCATION (Street a City or Town, State)	nd Number or Run	n' Route Number,
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: 2 MEDICAL EXAMINER: On							e(a) and manner as stated.
S BE C	29b, BIONATURE AND TITLE OF CERTIFIER		ranad	2	C' 1000	MBER 01675	29d. DATE SIGN	EO (Month, Day, Year)
F	30. NAME AND ADDRESS OF PERSON WHO CON	MPLETED CAUSE OF DEA		Box 91	3 SEA	FORD I	DE 19	9473
	31. DATE FILED (Month, Pay, Year) MAR 1 93	32. REGISTRAN'S SIGNA JUNE WAY DAY OS		-1-11				

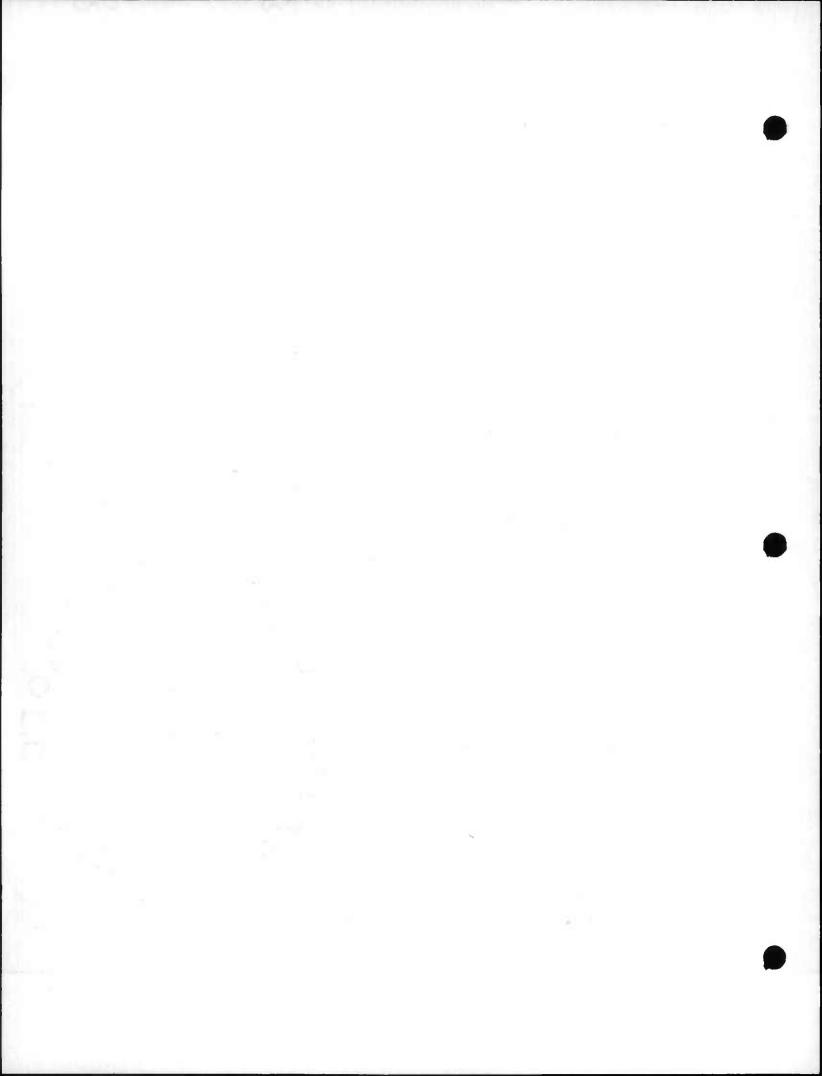


DHMH-18 Rev 1/89

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		1 - STATE REGISTRAR	STATE OF M				F HEALTH AN	D MENTA	L HYGIEN			
	1	1. DECEDENT'S NAME (First, Middle, Lest) EARL D.	21001	WIGHT		OUFFE	R SR.	MONT O	3 1	0 19	93 3.	TIME OF DEATH
pjn	j	4. SOCIAL SECURITY NUMBER 705-10-7460 9a. FACILITY NAME (If not institution, give s	5. SEX 1 M 2 F	6. AGE (In yrs. les	t birthday) YRS.		AYS HOURS MIN	AUG	OF BIRTH th, Day, Year) UST 4,	1893	Country) MAF	RYLAND
, 2, 3 should	стоя	WASHINGTON COL		SPITAL			ERSTOWN			WAS		GTON
it. Pages 1,	DIREC	10a. STATE 10b. COUNTY	, SHINGTON			Y, TOWN OR	STOWN				110.53	d. INSIDE CITY LIMITS? YES 2 NO
n. ansit permit.	IERAL	100. STREET AND NUMBER 331 MC DOWELL	AVENUE				101. ZIP CODE 21740			1	N OF WHAT	T COUNTRY?
215-0020 attending physician. se as the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE WI WW I	YES 2 1	MED 10	lf y	DECENDENT OF HIS is, specify Cuban, Me YES 2 NO Sp	xican, Puerto		or No — 14	Black, WI Specify:	American Indian, hite, etc.
D 2121 spital or atte ed for use a	APLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) Cottege (1-4 or 5 +) (G	ive kind of a Do NOT us	USUAL OCCU work done duri se retired.)	ng most of working	160	RAIL	ROAD	ITHY	
YLA by the be det	BE COM	17. FATHER'S NAME (First, Middle, Lest) DAVID HENRY	STOUF				MARI	A E	Middle, Melden LIZAE	BETH		HRER
E, MA y be retain age 5 sho be notiff	10	19a. INFORMANT'S NAME (Type/Print) EARL D. STOUFF 20g, METHOD OF DISPOSITION	ER JR.	1	250		AN DRIV		VER S		G,MD	
ALTIMORE death. Page 6 may tuneral director, pa		1 X Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE				N CEME		3-13-9	3 HAG	ERSTO	W, WA	SH.,MD.
~ ~ ~ ~		23. PART I. Enter the diseases, or o	Brady	anned the de	oth Do	40	E. ANTIE	TAM ST	., HAGE	RSTOWN	N,MD.	21740
S760, voted within 24 hours after 3 completely filled in by the urial, cremation, or remova- ic event, the medical	z	shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Due to	on each line	Live SUENCESON	Ha	Harb.	3/1	2 lux	all	22	Approximate interval Between Onset and Death
, P.O. BOX 6 eath certificate be exected attending physician and tail Hygiene prior to by y, or other traumat	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Olsease or injury that initiated events resulting in death) LAST	с	OR AS A CONSEC								
KECORDS, v requires that the dear been signed by the att r. of Health and Menta shows any Injury,	MEDICAL	PART II. Other significant condition	s contributing to	death but not r	esulting	in the unde	riying cause given	in Part I.	24a. WAS AN PERFOR 1 YES 2	MED?	AMA COI OF	MPLETION OF CAUSE DEATH?
Sept a	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:	26. PLACE OF DEATH	(Check only o	ne)			
PHYSICIAL this certification with the riced, or	BY PHYS	1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	1 Inpatient 2 28a. DATE OF (Month, Da	INJURY	28b. TIM	E OF 28	c. INJURY AT WORK?	28d. DE	SCRIBE HOW I	NJURY OCCU	RED	
OF ATTENDING DIRECTOR: After hours after death tem 28 is ma	ETED B	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF building.	F INJURY — At he atc. (Specify)	me, farm, s	street, factory	office	28f. LOI City	CATION (Street or Town, State)	and Number or	Rural Route	Number,
E 24 =	COMPL	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYST CHAPTER OF CHA	R: On the basis of ax									d manner as stated.
THE HOSP O THE FUND B filed within	TO BE	29b. SIGNATURE AND 1911 OF CENTIFIER	O COMPLETEO CAUS	SE-OF OFATH (ITE	M 277 (Vine	Printer	29c. LICENSE	NUMBER O	6	29d. DATE S	S///	onth/Dey, Year)
gasseria. Brasili 10		31. DATE FILED (Month, Day, Year)	28218	Dala R'S SIGNATURE	44	Die	Hage	ritc	XIII	no	2/	742
		iiAR 12 1993 <i>J</i>	the Binden	- Russil								S.M.V. 40 S. 40



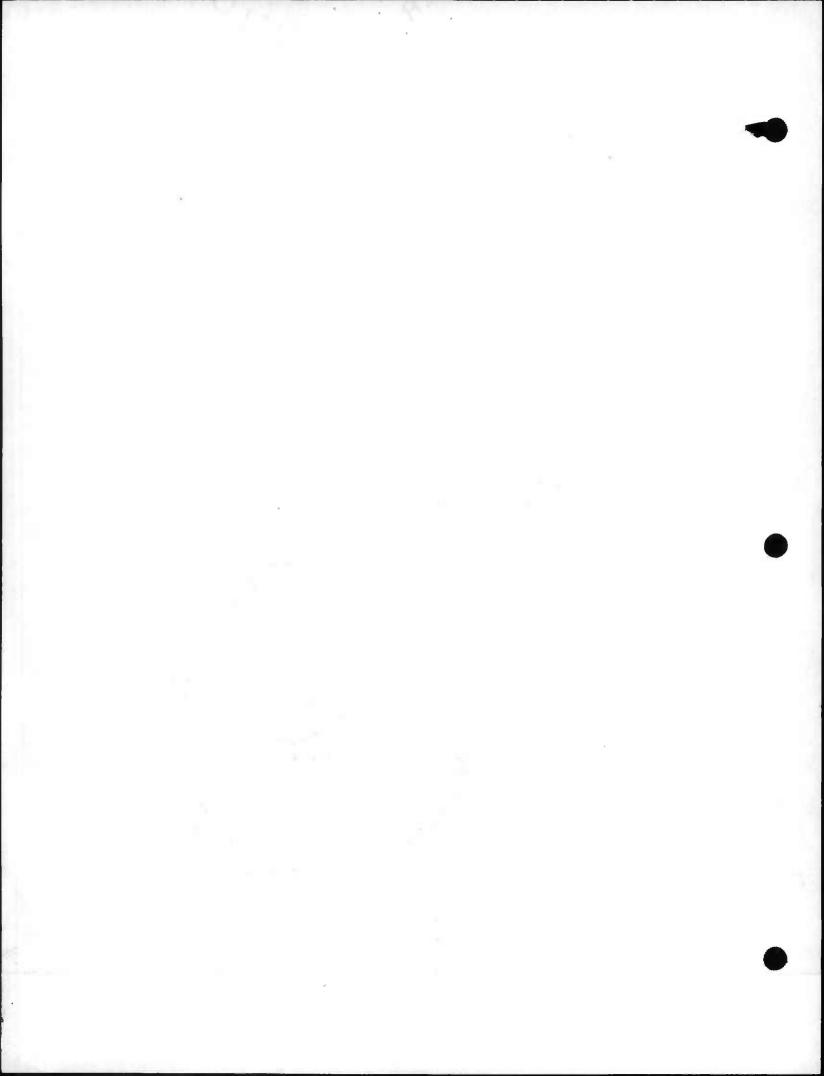
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BALTIMORE, MARYLAND	JO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	ertifica	ng phy	other
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	HOSP	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the filed within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal.	TANT
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1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

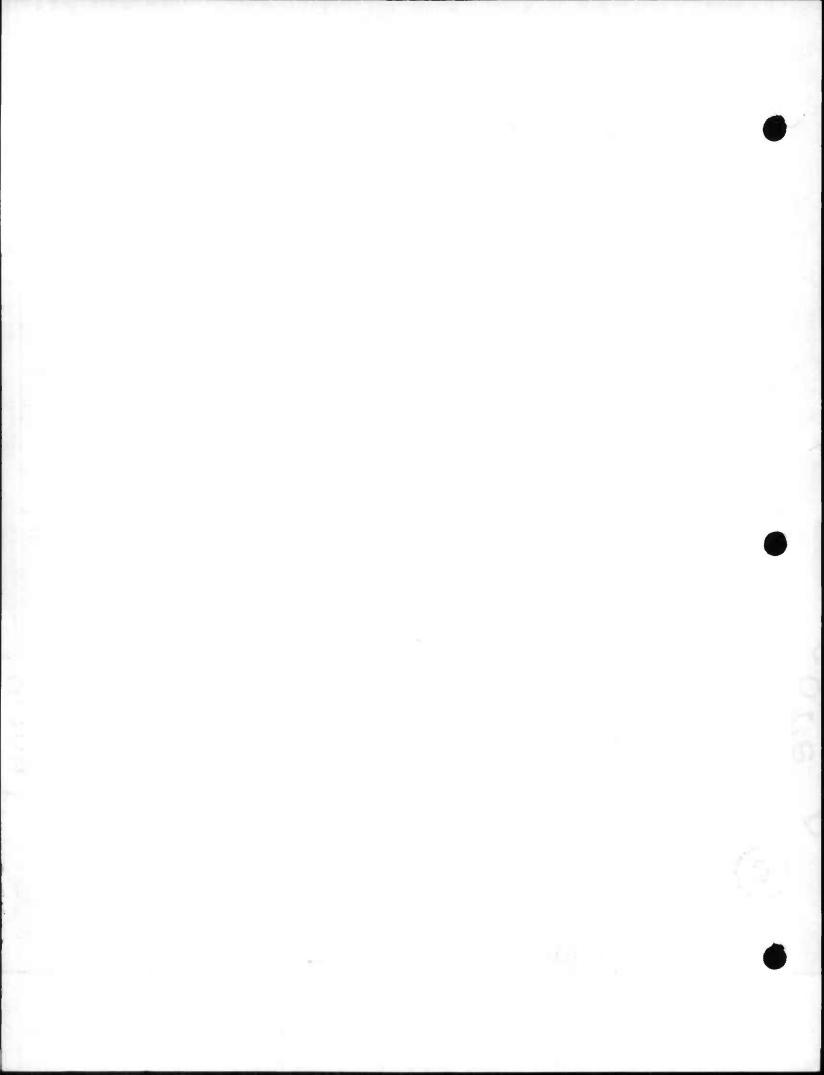
	nedistrian			T DEALL	HEG. N	J.	
1	1. DECEDENT'S NAME (First, Middle, Last) Stanley B	dward STOU	UFFER			DAY 1.0.0	YEAR 3. TIME OF DEATH
		GE (In yrs. last birthde		IR IF UNDER 24 HRS.	March 12	, 177	8. BIRTHPLACE (State or Foreign
		64 YRS	MONTHS DA		(Month, Day, Year)		Country)
	212-24-3303	04 TRS			Dec. 23,		Maryland
	9a. FACILITY NAME (If not institution, give street and number)			IN OR LOCATION OF I	DEATH	9c. COUN	ITY OF OEATH
DIRECTOR	Washington County Hospital		Ha	gerstown		Wa	shington
5	RESIDENCE OF DECEDENT						
2	10a. STATE 10b. COUNTY	10c,	CITY, TOWN OR LO				10d. INSIDE CITY LIMITS?
	Maryland Washington		Hagerst	own			1 TES 2 NO
A	10e. STREET AND NUMBER			10f. ZIP CODE		10g. CITI	ZEN OF WHAT COUNTRY?
FUNERAL	13434 Herman Myers Road			21742			USA
3	11. MARITAL STATUS 12. WAS DECEDENT EVI	ER IN U.S. ARMED	13, WAS	DECENOENT OF HISPA	NIC ORIGIN? (Specify Y	ns or No	14 RACE — American Indian
	1 Never Married 2 Married FORCES? 1 X IF YES, GIVE WAR O		If yes	, specify Cuban, Mexic	an, Puerto Rican, etc.)		14. RACE — American Indian, Black, White, etc.
BY	3 Wildowed 4 Divorced Korean C		٠' ا	YES 2 NO Spec	ny:		Specify: white
0	15. DECEDENT'S EDUCATION		T'S USUAL OCCUP	ATION	16b. KIND OF B	ISINESS/IND	
ETED	(Specify only highest grade completed)	(Give kind	of work done during Tues retired.)	most of working	102 1010 01 0	0011120071110	99181
121	Elementary/Secondary (0-12) College (1-4 or 5+)	17-		rol mgr.		aut	
COMPL	17. FATHER'S NAME (First, Middle, Last)	ZHVCHEC	Jry come				
8	Edward R. Stouffer				AME (First, Middle, Maide	n Surname)	
H					et Mowen		
2	19a. INFORMANT'S NAME (Type/Print)				Route Number, City or To		
-	Margaret Stouffer	134	434 Herm	an Myers	Rd., Hager	stown	, Md. 21742
	20a. METHOD OF DISPOSITION	20b. PLACE AND DA	TE OF DISPOSITION	(Name of	OATE 20c. L	OCATION —	City or Town, Stata
	1X Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Rest Ha	or other place)	eterv	3-17 Ha	perst	own, Maryland
	21. SIGNATURE OF FUMERAL SERVICE LICENSEE		22. NAM	E ANO ADDRESS OF F	ACILITY	80100	onni, iziz j zane
	· ZaMINhin	nuch		NICH FUNE		Issora	town, Md. 21740
	23. PART i. Enter the diseases, or complications that cau	sed the death D					
	shock, or heart failure. List only one cause of	n eech line.	o not enter the	mode of dying, so	cir as cardiac or res	piratory arr	est, Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition	. 0		CON			Onset and Death
	resulting in death) e.	inchog	QUIC	Care	ricoma		
1	DUE TO (OR /	AS A CONSECUENCE	OF):				
Z	Convenients that you divise to b.						
CERTIFICATION	If any, leading to immediate	AS A CONSEQUENCE	OF):				
3	CAUSE, Enter UNDERLYING CAUSE (Disease or Injury						
三	that initiated events DUE TO (OR /	AS A CONSEQUENCE	OF):				
ᇤ	resulting in death) LAST						
	BART II ON I III						
EDICAL	PART II. Other algnificant conditions contributing to deat	th but not resulting	ng in the underl	ying cause given in		N AUTOPSY PRMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
음	-				1 _ YES		COMPLETION OF CAUSE OF DEATH?
							1 YES 2 NO
2							
HYSICIAN	25. WAS CASE REFERRED TO MEDICAL		20	PLACE OF DEATH (C	heck only one)		
잃	EXAMINER?	Outpetlant 2 - DO	OTHER:				
¥	27. MANNER OF OEATH 28a, DATE OF INJU			INJURY AT	28d. OESCRIBE HOW	IN HIEW OCC	11050
0	1 Natural 5 Pending (Month, Day, Ye	ar)	INJURY	WORK?	28d. DESCRIBE HOW	MJUNY OCC	OHED
A	2 Accident Investigation			YES 2 NO			
6	building, etc. /	URY — At home, fari Specify)	m, street, factory,	iffice	281. LOCATION (Stree City or Town, State	t end Number e)	or Rural Route Number,
	4 Homicide determined	- 5				7	
12	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my k	nowledge, death occ	urred at the time,	sate end place, and du	e to the cause(a) and m	enner as state	ed.
COMPLET	one) 2 MEDICAL EXAMINER: On the basis of examin						· · · · · · · · · · · · · · · · · · ·
8						,	
H	296. SIGNATURE AND TITLE-OF CERTIFIER			29c. LICENSE NO	JMBER	29d. DATE	SIGNED (Month, Day, Year)
D 0	717001	ul		10214	3 (10	ען כן
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (7	ype, Print)	1 - 11.	1000 of	106	1021742
	MISDUL WATTERD, MD-	12821-6	JAKHI1	AVE. HA	+412125101	N. C.	ND21742
	31. DATE FIRED (MONT), Day god	HANKE IN					
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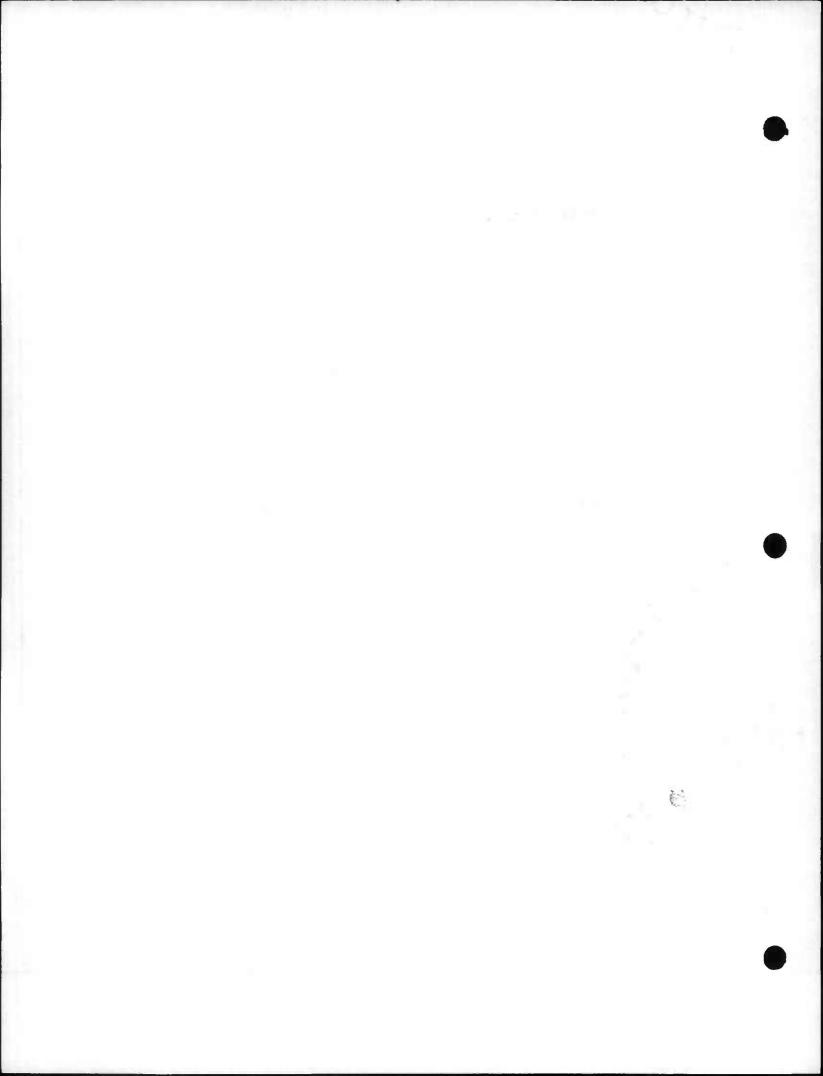
FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Midd 2. DATE OF DEATH 3. TIME OF DEATH 1993 YEAR DAY March 10, 0 7. DATE OF BIRTH
(Month, Day, Year)
June 4, 1900 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 216-46-5757 1 🗌 M 2 🔯 F Towa permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington County Hospital Hagerstown Washington RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Hagerstown YES 2 X NO 10a, STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 12810 The Terrace Estended 21740 use as the burial-transit **USA** hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Marrie 1 TES 2 NO Specify BY 3X Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest gr 12 years jo College (1-4 or 5+) 4 years detached home extension representative 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Malden Sumame) Irvin Clyde Martin Ħ Nellie Oliver page 5 should be BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Donna Moats 83 W. Washington Street Hagerstown, Maryland 21740 9 20e. METHOD OF DISPOSITION
1 ||X| Burlai | 2 | Cremation | 3 | Removal from State
4 || Dogetton ||5 || Other (Specify) | 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE funeral director, must Rose Hill Cemetery 3/16 Hagerstown, Maryland medicai examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland the or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the attending physician and completely filled in by 1 Mental Hyglene prior to burial, cremation, or remor shock, or heart failure. List only one on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final event, the men morne disease or condition resulting in death) atesal DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING OR ATTENDING PHYSICIAN: The law requires that the death certificate be to DIRECTOR: After this certificate has been signed by the attending physician hours after death with the State Dept. of Health and Mental Hyglene prior to item 28 is marked, or Item 23 shows any injury, or other traun CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 34b. WERE AUTOPSY FINDINGS emers PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? t ☐ YES 2 ☐ NO 1 YES 1 HO PHYSICIAN: 25. WAS CASE REFERRED 30 MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINENT 1 YES 2 THO HOSPITAL: M 2 DENOVO ADO DE S ZT. MANNED OF DEATH 28s. DATE OF INJURY 28c. INJURY AT 5 Pending 1 YES 3 NO BY 2 Acciden 28s. PLACE OF INJURY --- At home, farm, street, facto 3 🔲 Buicide 281. LOCATION (Street and Number or Rural Route Number City or Team, State) 6 Could not be BE COMPLETED 4 | Homicid To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. IMPORTANT: II 2 LETED CAUSE, OF DEATH (ITEM 27) (Typ ale 31. DATE FILED (Month, Day. 32. REGISTRAR'S SIGNATURE his Bendeau Franklik



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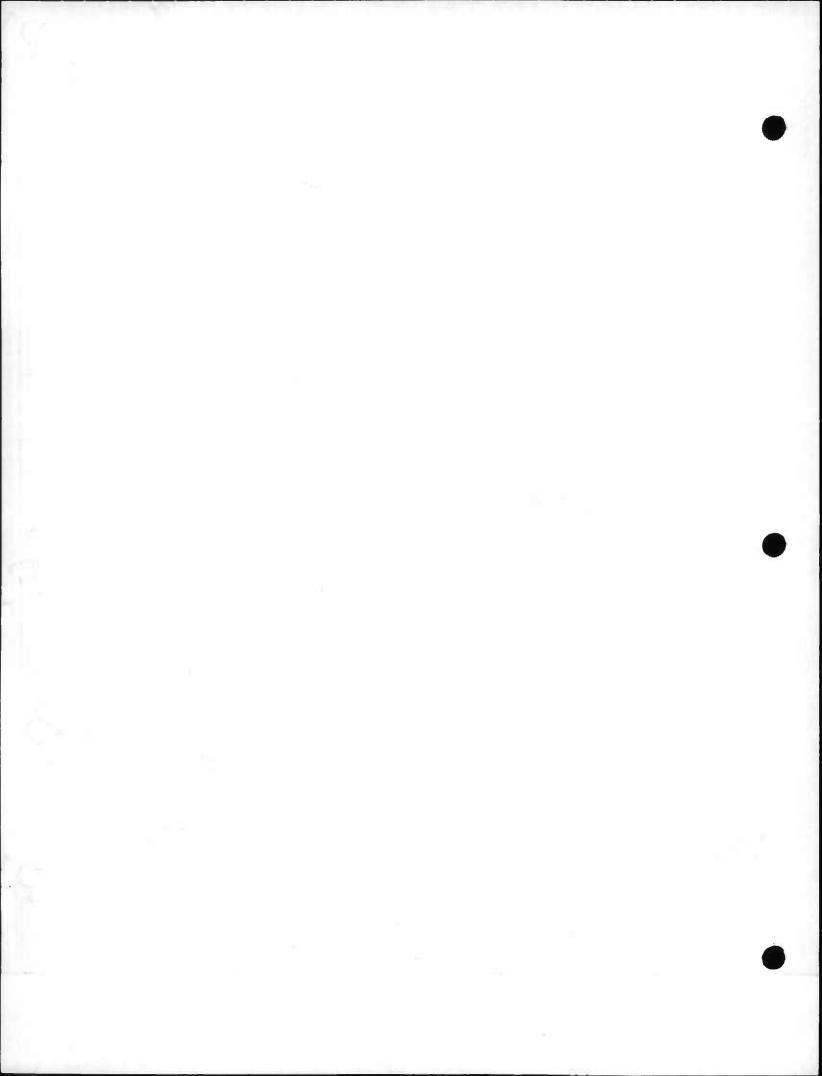
JAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	he State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	ter item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
death certific	e attending ph	Aental Hygiene	ury, or othe
w requires that the	been signed by th	it, of Health and &	shows any ini
rSICIAN: The lan		h the State Dep	-
ENDING PHY	R. After this	hin 72 hours after death with the	is marked.
AL OR ATTE	VERAL DIRECTOR:	2 hours after	TANT: If Item 28
E HOSPIT	FUNERA	within 7	RTANT:

	REGISTRAR		CL	COLL	CATE OF	DEATH	H	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF I				3. TIME OF DEATH
1 1	Mary Ellen SHENK						March	11.		YEAR	2130 m
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest	birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF E		1		IPLACE (State or Foreign
	214-05-7419	1 M 2 F	75	YRS.	MONTHS DAYS	HOURS MIN.	(Month, De	y, Year)	7	Countr	γ)
1 4			/3	11101			Nov. 3	,191		_	wn, Md.
00	Se. FACILITY NAME (If not institution, give stre				9b. CITY, TOWN	OR LOCATION OF D	EATH		9c. COUR	ITY OF D	EATH
Ö	Washington County	Hospita]	<u>L</u>		Hage	rstown			Was	hing	ton
2	10a. STATE 10b. COUNTY			44 4-	, TOWN OR LOC						
DIRECTOR				10c. C111	, IOWN OR LOCA	ATION					10d. INSIDE CITY LIMITS?
	Maryland Washin	ngton		На	gerstow	n					1 X YES 2 NO
AL	10s. STREET AND NUMBER					Of. ZIP CODE			10g. CITI	ZEN OF V	VHAT COUNTRY?
E .	193 West Wilson Bo	oulevard				21740				USA	
FUNERAL		12. WAS DECEDENT			13. WAS DE	CENDENT OF HISPA	NIC ORIGIN? (S	pecify Yes	or No-	14. RACI	E American Indian,
	1 Never Married 2 Married	FORCES? 1 [YES 2 N	0	If yes, s	pecify Cuben, Mexic S 2 X NO Speci	an, Puerto Ricar	, etc.)		Black	k, White, etc.
BY	\$☐ Widowed 4 ☐ Divorced	11 120, 0112 1	IN ON DATES		''''	S Z Z NO Speci	ry:			whi	
0	15. DECEDENT'S EDUC	ATION	18a. DEC	CEDENT'S	USUAL OCCUPAT	ION	16b KIN	D OF BUS	INESS/IND	_	
	(Specify only highest grade of		(Gh	ve kind of w Do NOT use	rork done during n	nost of working	Touc rais	0 01 000	11000/1100	031111	
12	Elementary/Secondary (0-12)	College (1-4 or 5 +)		ouse							
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	U	11	iouse	WILE	_					
						18. MOTHER'S NA	THE RESERVE		Sumame)		
띪	Charles Price Ada	ns				Berth	a Twigg	3			
10	19a. INFORMANT'S NAME (Type/Print)		19b.	MAJLING	ADDRESS (Street	and Number or Rural	Route Number, C	ity or Town	, State, Zip	Code)	
-	David Shenk		9	620	Lawnda1	e Court,	Silver	Spri	ng,	Md.	20901
	20a. METHOD OF DISPOSITION				F DISPOSITION (DATE	20c. LOC	CATION —	City or To	wn, State
	1 Donation 5 Other (Specify)	val from State	Rose	Hill	Cemete	rv	3-16	Hage	rsto	wn.	Maryland
1	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE				ND ADDRESS OF F				,	
	3 4	ww	-	1	MINNI	CH FUNER	AL HOMI	€			
	Saw!	11/11	nne	K	415 E	. Wilson	Blvd.	Hag	gerst	own,	Md. 21740
	23. PART i. Enter the diseases, or co	emplications that	caused the dea	ith. Do n	ot enter the m	ode of dying, suc	ch aa cardiac	or respir	ratory arr	est,	Approximate
	shock, Dr heert failure. L iMMEDIATE CAUSE (Final	let Dnly one ceus	le Dri eech line.		1	(/				Interval Between Onset and Death
1 1	disease or condition	Air	h 9/	111	1100	Tat.	1 cont	111			
	resulting in death)	DUE TO (OR AS A CONSEO	D C 7	V C, H	1.	106-11	- 7			
	resulting in death)	DUE TO (OR AS A CONSEQ	UENCE OF	1:	1.	106-17				
NO	Sequentially list conditions,						NV (- //				
ATION	Sequentielly list conditions, if any, leading to immediate		OR AS A CONSEQ				NV (7/)				
FICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (DR AS A CONSEQ	UENCE OF	7):	<i></i>	NV (- 1/)				
TIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (UENCE OF	7):	<i></i>	NV (- 1/)				
SERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (DR AS A CONSEQ	UENCE OF	7):	<i></i>	NV (- 1/)				
L CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (DR AS A CONSEQ	UENCE OF); j;	ng ceuse given in	Part i. 24	. WAS AN	AUTOPSY	24b	WERE AUTOPSY FINDINGS
	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (DR AS A CONSEQ	UENCE OF); j;	ng ceuse given in		PERFOR	MED	24b	MAILABLE PRIOR TO
DICAL	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (DR AS A CONSEQ	UENCE OF); j;	ng ceuse given in			MED	24b	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (DR AS A CONSEQ	UENCE OF); j;	ng ceuse given in		PERFOR	MED	24b	AMAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions	DUE TO (DR AS A CONSEQ	UENCE OF); j;	ng ceuse given in		PERFOR	MED	24b	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions 25. WAS CASE REFERRED TO MEDICAL	DUE TO (DR AS A CONSEQ	UENCE OF	n the underlyle	ng ceuse given in	1	PERFOR	MED	24b	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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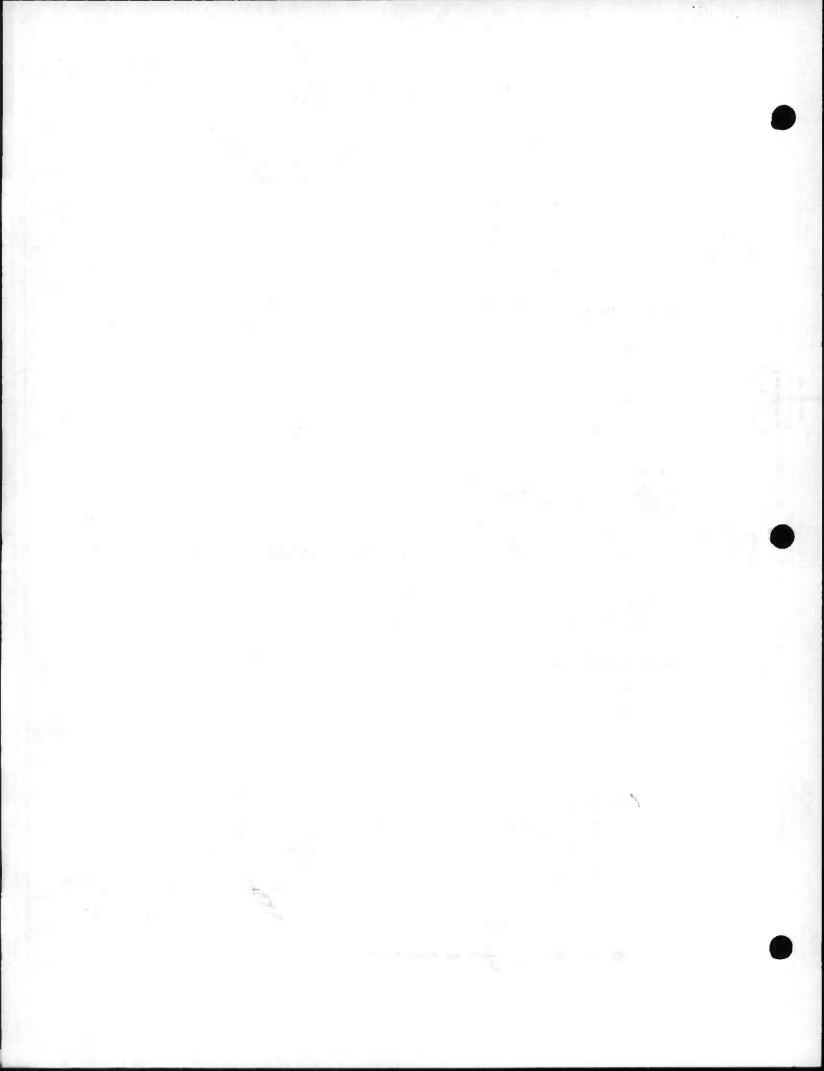
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	4. SOCIAL SECURITY NUMBER		. AGE (In yrs. la		IF UNDER 1 YEAR MONTHS DAYS	HOURS	R 24 HRS.	7. DATE (Mon	OF BIRT	TH bar)	B. BIRT	THPLACE (State or Foreigntry)
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N	419 Michigan Ave						740				US	
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT E FORCES? 1	YES 2 X			CENOENT (pacify Cubi				Ify Yes or No— Ic.)	14. RA	CE - American Indian, ick, White, etc.
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BE	David Franklin H	leckman					lice					
2	19a. INFORMANT'S NAME (Type/Print)				ADDRESS (Street							
	Jean Carbaugh		_		atawba		e, H					
	20a. METHOD OF OISPOSITION 1 ☑ Burlai 2 ☐ Cremetion 3 ☐ Re	moval from State	20b. PLACE cemetery, cre	ANO OATE O	FOISPOSITION (N her place)	lame of		OAT		Dc. LOCATION -		
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- 1	23. PART I. Enter the diseases, or shock, or heert fellure	compilections that co. List only one couse	aused the de	eath. Do n	415 E	. Wil	lson	B1v	d.,	Hagers respiratory	town	Approximate interval Betw
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HIGSFIFML DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos	METAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	after 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	TANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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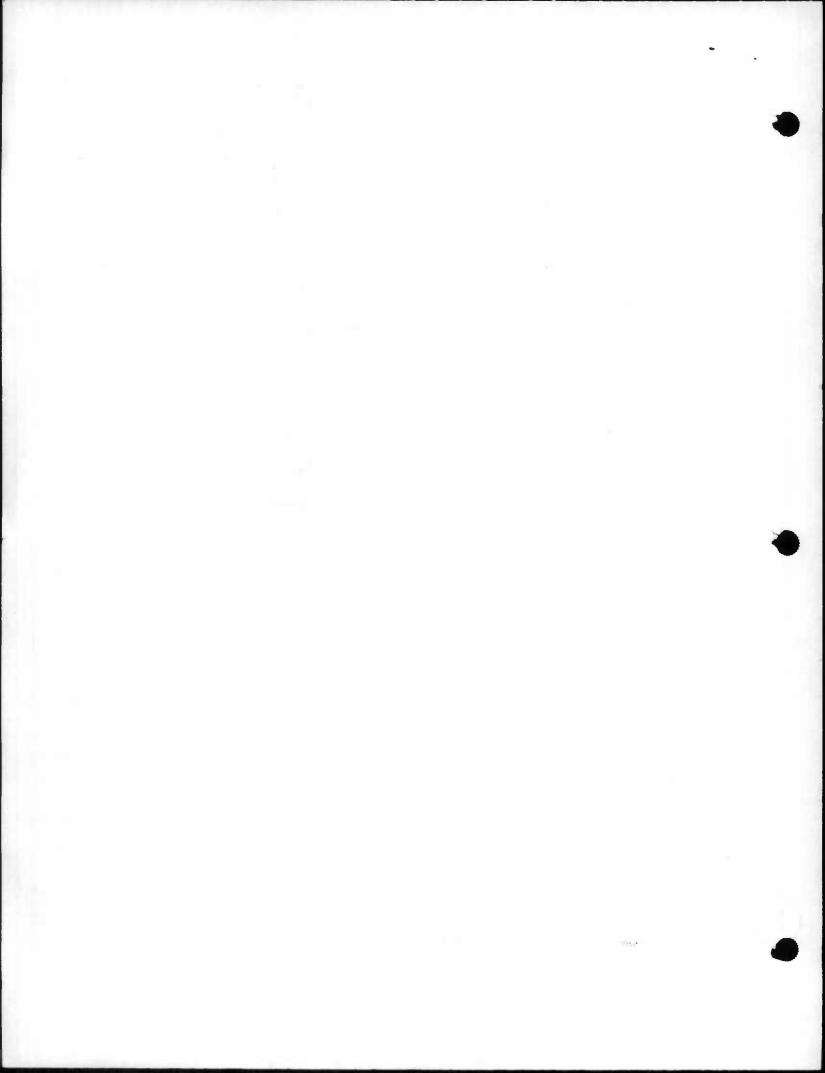
1 - STATE REGISTRAR	STATE OF MARY	CERTIF) MENT	REG. NO.	E	
1. DECEDENT'S NAME (First, Middle, Las	()					2. DAT	E OF DEATH	V VI	3. TIME OF DEATH
HOWARD	VERNON	SHADE					Mar.13		
4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)	IF UNDER 1		UNDER 24 HR	(Moi	E OF BIRTH	1	BIRTHPLACE (State or Foreign Country)
236-54-8492 9e. FACILITY NAME (If not inetitution, give	t M 2 MAF	56 YRS.	Ob CITY	TOWN OR L	DOATION OF		05/02/3	9c, COUNTY	WEST VIRGINIA
						DEATH			
RESIDENCE OF DECEDENT				REDER	TOV			FRE	DERICK
MD	FREDERICK		REDER	RICK					10d. INSIDE CITY LIMITS() 1 YES 2 NO
10e. STREET AND NUMBER 6913 BOWERS RD 11. MARITAL STATUS	•			10f. ZIP		21791		tog. CITIZEN	U.S.A.
3 Widowed 4 DPWorded	12. WAS DECEDENT EVER FORCES? 1 TYES, GIVE WAR OR YES	S 2 NO	lf.	VAS DECEND yes, specify YES 2			IN? (Specify Yes Rican, etc.)	or No— 14.	RACE — American Indian, Black, White, etc. SpecificHTTE
15. DECEDENT'S EI (Specify only highest ora Elementary/Secondary (0-12) 1 2 17. FATHER'S NAME (First, Middle, Last)	OUCATION ide completed) College (t-4 or 5 +)	16a. DECEDENT'S (Give kind of life. Do NOT us	work done di se retired.)	CUPATION uring most of	working	te	b. KIND OF BUS		
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ARNOLD BRENT S 190. INFORMANT'S NAME (Typo/Print)	HADE	T 10h MAH ING	Annaces	(Street and N			MASON nber, City or Town	. O	4.
JEFFERY V. SHA	DE			COUR I		KEY		r, State, Zip Coo	MD 21757
20e. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Re 4 Donation 6 Other (Specify)	DIEDWIT	Ob. PLACE AND DATE OF RESTHA							or Town, State RICK, MD
21. SIGNATURE OF FUNERAL SERVICE		ler	_	AME AND A	DORESS OF	FACILITY			ZLER & SONS
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PART II. Other aignificent condition	one contributing to death	but not resulting	In the und	ierlying ce	use given	In Part I.	24a. WAS AN / PERFORI		24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE
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25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				OF DEATH	Check only o	ne)		
t VES 2 NO	t - Inpetient 2 - ER/O		OTHER:	ng Home 5	Residence	e 6 🗆 Oth	er (Specify)		
27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJUR (Month, Day, Year	Y 28b. TIM	E OF 2	26c. INJURY WORK? t YES	2 NO	28d. DE	SCRIBE HOW IN	JURY OCCUR	ED
	26e. PLACE OF INJU building, etc. (S)	RY — At home, farm, a pecify)	street, factor	ry, office		26t. LO	CATION (Street as or Town, State)	nd Number or F	Rural Route Number,
	SICIAN: To the best of my known NER: On the basis of examination								ouse(a) and menner as stated.
Sudiew 7	and f	an		29c	1351	1UMBER		29d. DATE SH	
30. NAME AND ADDRESS OF PERSON W ANDREW ZARICK,		PEATH (ITEM 27) (Type,		רוע כידי	1.7	AI KED	SVILLE,	MD	
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SK		ואחתר	OK 21	• W	drvr.	OVILLE,	, דוח	



BALLIMORE, MARTLAND ZIZUS-3146	- Nours after death. Page 6 may be retained by the hospital or attending physician.	D THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should acted to the page of the page of the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.	he medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 13146,	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the factor and completely filled in by the factor and completely filled in by the factor and the factor and the factor and fac	med white it incurs are been with the Case cop. Or treatment and injury, or other traumatic event, the medical examiner must be notified at once.	

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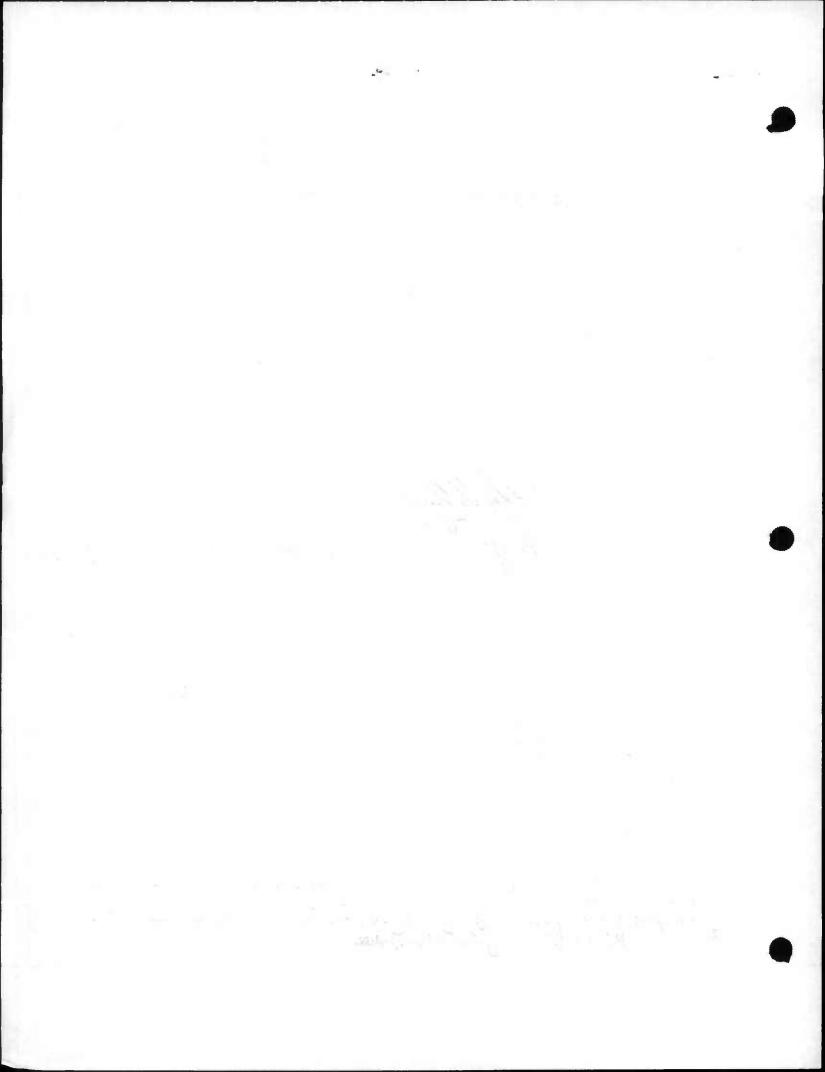
	FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM			MENTAL HYG		3 (18961
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEA	TH DAY V	3. T	TIME OF DEATH
ľ	VERA I	LUCILLE	SCHWARZ			Mar.	11, 1993	ion	8:17PM M
	4. SOCIAL SECURITY NUMBER		yrs. last birthday)IF L	INDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT (Month, Day, Ye	ari	BIRTHPLAG Country)	CE (State or Foreign
	577-20-1105 9a. FACILITY NAME (If not institution, give s	1 - M FEMALE	77 YRS.		R LOCATION OF DE	02/15	/16 9c. COUNTY	OHIO	1
TOR	365 PLEASANTON F	₹D.		WESTM	MINSTER		CAR	ROLL	
DIRECTOR	10a. STATE 10b. COUNTY			WN OR LOCATE			<u>-</u>	10d	I. INSIDE CITY LIMITETES YES 2 NO
	10e. STREET AND NUMBER			101.	ZIP CODE		10g. CITIZEN		
FUNERAL	365 PLEASANTON F				211	157		U.S	S.A.
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Proposed	12. WAS DECEDENT EVER IN U. FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 NO		ENDENT OF HISPAN Helfy Cuban, Mexican 2 NO Specify	n, Puerto Rican, et		Black, Wit Specify:	
8	15. DECEDENT'S EDU	ICATION 10	6e. DECEDENT'S USU	AL OCCUPATIO	N .		F BUSINESS/INDUS	TRY	
	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work of life. Do NOT use reti	done during mos red.)	st of working				
린	12	4	NURSE				HEALTH A	SSOC:	IATION
COMPLET	17. FATHER'S NAME (First, Middle, Last)				18, MOTHER'S NAI				
BE	WILLIAM BALSBAU	GH			FAI	NNIE BRO	WARD		
10	19a. INFORMANT'S NAME (Type/Print)						or Town, State, Zip Co		01701
	BARBARA S. BROWN				YS MILL I			MD	21791
	20a. METHOD OF DISPOSITION 1	ioval from State 200. P	PLACE OF DISPOSITION (THE PIECE) PARKLAWN			20	ROCKVI		
-	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE / /	PARKLAWN		D ADDRESS OF FAC	CILITY D	D. HART		
	* (atharine	2. Xailler		11/14	NEW V	WINDSOR,			a bonb
	23. PART I. Enter the diseeses, or ahock, or heart feliure.	complications that gaused to List only one cause on and	ha death. Do not a h iine.	inter the mo-	de of dying, auci	h aa cerdlec or	respiratory erres	l,	Approximate interval Batween
	iMMEDIATE CAUSE (Fine)			. 1	1.				Onset and Death
	resulting in death)	DUE TO (OR AS A C	ONSEQUENCE OF):	my to	HIUM				immen.
N	Sequentielly list conditions,	DUE TO (OR AS A D	CA, 1	metA	states	•			unertain
F	if eny, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A C	ONSEQUENCE OF):						
CERTIFICATION	CAUSE (Disease or injury that initiated events	C. DUE TO (OR AS A C	ONSEQUENCE OF):						
E	resulting in death) LAST	d							
	PART il. Other aignificant condition	ne contributing to death but	not requiting in th	a underlying	a course olimp in	Bart i 24a W	AS AN AUTOPSY	T 245 WE	RE AUTOPSY FINDINGS
MEDICAL	TANT II. Other alginicant condition		. Hot readiting in ti	ie underlyni	A cansa Aisan iii	P	ERFORMED?	AVI	MLABLE PRIOR TO
ED						_ '''	ES 2 NO	1	DEATH?
								''	_ 123 2 (<u>M</u> 110
AN	25. WAS CASE REFERRIDO TO MEDICAL			26. PL	ACE OF DEATH (Ch	eck only one)			
SIC	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpate		HER: Nursing Hom	e 8 Residence	8 Other (Special	(y)		
PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	WO		28d. DESCRIBE	HOW INJURY OCCUI	RED	
BY	2 Accident Investigation	28a. PLACE OF INJURY —	At here they store		YES 2 NO	204 1 00471041	One of a sel Nove to a se	D	- More
TED	3 Suicide 8 Could not be 4 Homicide detarmined	building, etc. (Specify		t, metory, offic		City or Town,	Street and Number or State)	nurai riouti	e reumber,
COMPLETED	0001	SICIAN: To the best of my knowled							d menner as stated.
	296. SIGNATURE AND TITLE OF CERTIFIE	1			29c. LICENSE NUI	WBER			onth, Day, Year)
D BE	1/104	, wy M	>		033	599	1 3	12	93.
٩	30. NAME AND ADDRESS OF PERSON WI		TH (ITEM 27) (Type, Prin 25 AIRPOR'		E. SUITE	24 W	ESTMINSTE	ER. M	ID 21157
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNAT			_,	<u> </u>		9 11	



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DIVISION OF VITAL RECORDS, P.	
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DALLINOTE, MANIENCE STORES, TO SEE STORES OF SECTION SECTIONS	THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should filled within 27 hours when change high the change has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	menor with the country of the countr	IMPORTANT: IT IVENT 2.6 IN MATRICU, OF INSM 2.3 SHOWS 2NY INJURY, OF OTHER TRAINGREWIT, THE MEDICAL EXAMINER MUST BE NOTITIED AT ONCE.	
1	3	1	1	-	

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM			ENTAL HYGIEN		08962
	1. DECEDENT'S NAME (First, Middle, Last) Edna May Spark					2. DATE OF DEATH P. MONTH MARCH	'3 i'	3. TIME OF DEATH 998 4:30 PM
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8.	BIRTHPLACE (State or Foreign
	215 - 20 - 4571 Da. FACILITY NAME (If not institution, give	1 D M 2 🕮 F 89	YRS.	AITHS DAYS		March 21,	1903	Maryland
FUNERAL DIRECTOR	The Kent & Oueer				ertown	тн	Kent	
REC	10a. STATE 10b. COUNT	TY		OWN OR LOCAT	ION			10d. INSIDE CITY
LD	Maryland K	Cent	Che	sterto	VI)		L	1 TES 2 NO
ERA	205 Deep Landin	ig Road			21620		10 10 10	S.A.
FUN	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC		ORIGIN? (Specify Yes		. RACE — American Indian, Black, White, atc.
ВУ	3 N Widowed 4 Divorced	IF YES, GIVE WAR OR DA			2X NO Specify:			specify: White
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad	UCATION le completed)	16a. DECEDENT'S USI	done during mos	N st of working	16b. KIND OF BUS		
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homemake			Domost	10	
OM	17. FATHER'S NAME (First, Middle, Leet)		Tromemake	1	16. MOTHER'S NAME	Domest (First, Middle, Malden		
BE (William Moore					Savington		
5	19a. INFORMANT'S NAME (Type/Print) Jeanette Coleman					Class the seal		
	20a, METHOD OF DISPOSITION 1 N Buriel 2 Cremation 3 Ren	206	PLACE AND DATE OF D	SPOSITION (Na		Chestert		C Z16ZU
	4 Donation 5 Other (Specify)	Cr	etery, crematory or other umpton Ce	metery			umpton	, Md
	21. SIGNATURE OF FUNERAL SERVICE LI	1 / /	PN		vs - Well	s Funeral	Home	
Н	▶ William L. K	1000	Key	Cheste	ertown. Me	d 21620		
	23. PART I. Enter the diseases, or shock, or heert fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	s. Myo (a	CONSEQUENCE OF	enter the mod) ^	to N	retory srrest,	Approximate interval Between Onset and Daeth
CERTIFICATION	Sequentisity list conditions, if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	bDUE TO (OR AS A d	CONSEQUENCE OF):					
N: MEDICAL	PART II. Other algolificant condition	na contributing to death be	ut not reaulting in t	he underlying	csuse given in Pa	24a. WAS AN PERFOR 1 TYES 2	MED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSBITAL:	0	26. PL	ACE OF DEATH (Check	only one)		
HYS	1 TYES 2 TMO	1 Pinpatient 2 ER/Outp		Nursing Home	5 ☐ Residence 6	Other (Specify) 8d. DESCRIBE HOW IF	NJURY OCCUR	ED.
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	tNJURY	WOR	RK7 ES 2 NO			
	3 Sutcide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, term, stree	t, factory, office	2	8t. LOCATION (Street a City or Town, State)	nd Number or R	Bural Route Number,
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS	RCIAN: To the best of my knowl ER: On the besis of examination	edge, death occurred at	the time, data	and place, and due to	the cause(a) and man	ner as stated.	
8	206. SIGNATURE AND TITLE OF DESITIFIE				29c. LICENSE NUMBE			GNED (Month, Day, Year)
TO BE	40. MANE AND ADDRESS OF PERSON W	O COMPLETED CALIFIC OF THE	TH (ITEM 27) (Type, Prin		01649	3 5	13	16 93
	Wayne D. Beni	iamin the	2 (1	rester	town	MD	21	620
5	31. DATE FILED (MONIMAR 10 7 1	32 REGISTRATS BIGNI	Davidson-Rang	lell				



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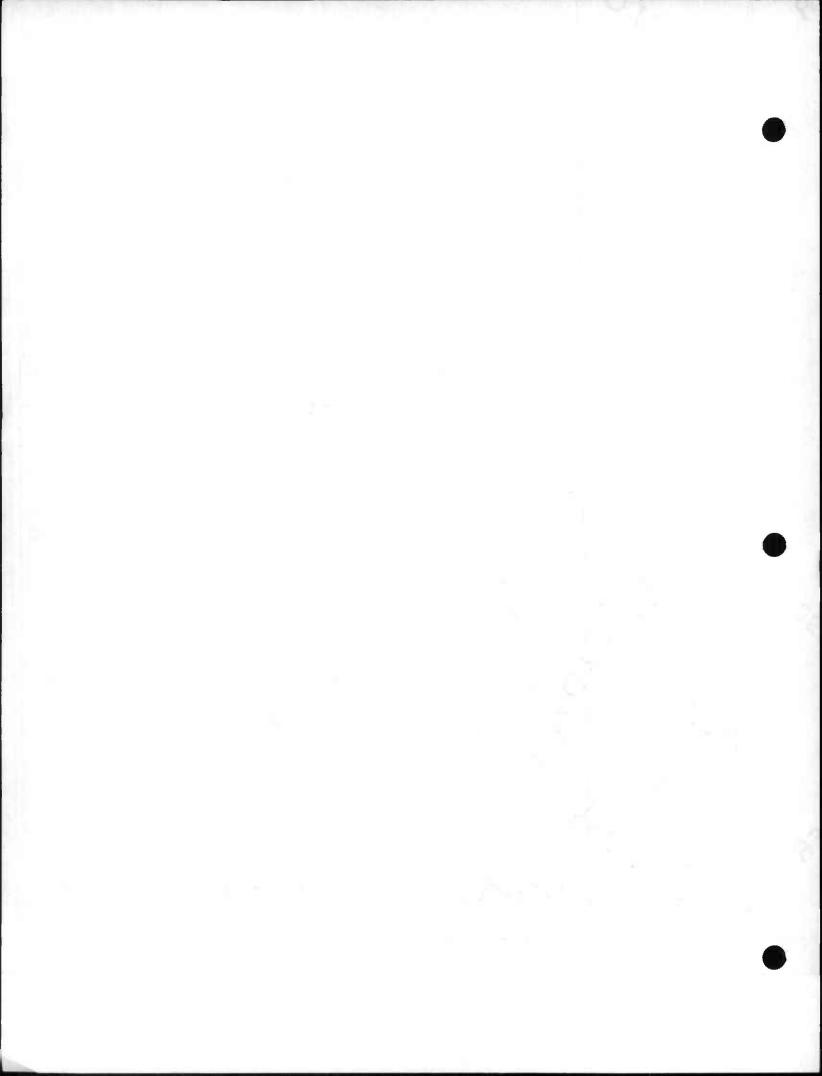
08963 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 3 FOR STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Adelaide 1993 ANNA STEINERT MARCH 14, 0505 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs, last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 2 (Mg/nth, Day, Year) 12 IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 059 01 5700 New York 81 1 M 2 XF 9a. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH CALVERT MEMORIAL HOSPITAL DIRECTOR PRINCE FREDERICK CALVERT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Prince FRederick Calvert Maryland 1 - YES 2 X NO FUNERAL 10g. CITIZEN OF WHAT COUNTRY? USA101. ZIP CODE (Calvert Co. Nursing Center) 20678 Hospital Grounds 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, Whits, etc. 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify. white 8 3 Wildowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) bookkeeper Travel 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumerne) SUSANNA Franko Fritz Scheufele BE 19s. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Rown, State, Zip Code) 7381 Alta Vista Circle Huntington Beach Calf. 92647 2 Robert E. Kraig 20a. METHOD OF DISPOSITION 20b.PLACE AND DATE OF DISPOSITION (Name of 3/1/79/49/3)
COMMENCE COMPANY OF THE REPORT 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Buriel 2 CKCremation 3 - Removal from State 4 Donation 5 Other (Specify) lexandria Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximeta shock, or heart failure. List only one ceuse on each line. Interval Between Onset and Death **IMMEDIATE CAUSE (Finel** Heroscienotic Real Diseas disease or condition resulting In death) MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? resnoma 1 YES 2 NO eriphe Dis en PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident INJURY 5 Pending Investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined COMPLETED 4 Homicide CERTIFIER (Check only one)

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER B 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 1. Shap 7.22634 3-16-93. 2

MAHESH P. SHAH, M.D., PRINCE FREDERICK, MD. 20678

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. RECISTRAR'S SIGNATURE SIGNATURE SIGNATURE



1 - STATE REGISTRAR	TALL OF MAIL		CATE OF		RE	G. NO.			
1. OECEOENT'S NAME (First, Middle, Last)					2. DATE OF DE		WEAR	3. TIME OF OEA	ГН
HARRY FELTON SEAL	E				монтн 03	21	93	0420	Αм
4. SOCIAL SECURITY NUMBER 5. S	SEX 6. A	GE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIF			IPLACE (State or Fi	
215-12-8070	M 2 🗆 F	90 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, 07 25		Count	‴Virgir	ia I
9e. FACILITY NAME (If not institution, give street e	and number)		9b. CITY, TOWN	R LOCATION OF OE			UNTY OF C		10
SACRED HEART HOSP	ITAL		CUMBER	LAND		A	LLEGA	NY	
10e. STATE 10b. COUNTY		10c. CIT	, TOWN OR LOCAT	TION				10d. INSIDE CITY	,
Maryland Allega	nv	Wes	sternpor	t.				1 YES 2 X	NO
10e. STREET AND NUMBER		1 110		. ZIP CODE		10g. C	ITIZEN OF	WHAT COUNTRY?	
200 Clayton Avenue				21562			U.S.		
1 Never Married 2 Married	WAS DECEDENT EVI FORCES? 1 1 1 IF YES, GIVE WAR O	ES 2 NO	If yes, sp	ENDENT OF HISPAN ecity Cuban, Maxica 2 (X NO Specify	n, Puerto Rican,		14. RAC Blac Spec	E — American Indi k, White, etc. elly: White	
15. OECEDENT'S EDUCATIO (Specify only highest grade comp		16a. DECEDENT'S	USUAL OCCUPATION	ON set of working	16b, KINO	OF BUSINESS/I	NDUSTRY		- 1
	llege (1-4 or 5+)	life. Do NOT us	e retired.)	or or worning					
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle,	Maiden Surname)		
Charles Seale				Elizab	eth Sea	ale			
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	and Number or Rural I			Zip Code)		
Jesse Seale		Mad	ison, VA	22727					
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal	from State	20b. PLACE ANO DATE of cemetary, crematory	or other place)	(Name		20c. LOCATION	-	own, State	
4 Donetion 5 Other (Specify)	FF	Etlan Ce		ND ADDRESS OF FA	3/24/93	Etlar	n. VA		
A. alame	5 6	70	Clo	re Funer	al Home		VA	00701	
23. PART i. Enter the diseases, or comp	olications that car	used the death. Do r		O. Box 10				22701 Approxim	aste
ahock, or heart failure. List IMMEDIATE CAUSE (Finel disease or condition resulting in death)		PIRA TOR	X FA	HILURE	;			Interval E Onset an	
Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		AS A CONSEQUENCE OF	Pi J	IMON.	(A				
PART ii. Other algnificant conditions co	entributing to dea	th but not resulting	in the underlyin	a cause alven in	Part i. 24a.	WAS AN AUTOPS	Y 24	b. WERE AUTOPSY (FINDINGS
ARTERIOSCIE		KEART				PERFORMED?	,	AVAILABLE PRIOR	
CONGESTIVE	NEA		LLUR		_ ' '	YES 2 TAO		OF DEATH?	NO
DARKINSON	15	DISEA	-SZ		_				
25. WAS CASE REFERRED TO MEDICAL		8	26. P	LACE OF GEATH (Ch	eck only one)				
EXAMINER?	OSPITAL:	Outpatient 3 DOA	OTHER:	ne 5 🗆 Residence	8 Other (Soe	olfv)			
27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJU	JRY 28b. TIM	E OF 28c, IN.	JURY AT DRK? YES 2 NO		E HOW INJURY	OCCURED		
2 Accident Investigation 3 Suicide 8 Could not be detarmined	28e. PLACE OF IN. building, etc.	JURY — A1 home, farm, (Specify)	street, factory, offic	ca	281. LOCATION City or Tow	(Street and Num vn, State)	ber or Rural	Route Number,	
29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN DESCRIPTION OF THE PHYSICIAN DESCRIPTION OF THE PHYSICIAN DESCRIPTION OF THE PHYSICIAN DESCRIPTION OF THE PHYSICIAN DESCRIPTION OF THE PHYSICIAN DESCRIPTION OF THE PHYSICIAN DESCRIPTION OF THE PHYSICIAN DESCRIPTION OF THE PHYSICIAN DESCRIPTION OF THE PHYSICIAN DESCRIPTION OF THE PHYSICIAN DESCRIPTION OF THE PHYSICIAN DESCRIPTION OF THE PHYSICIAN DESCRIPTION OF THE PHYSICIAN DESCRIPTION DESCR								(a) and manner as	stated.
29b. SIGNATURE AND TITLE OF CERTIFIER	ngry	- N		D 2 5	6 38	29d. D	3/	0 (Month, pay, Year 2 / 9	3
30. NAME AND ADDRESS OF PERSON WHO CO	URG P.	LAZA, E	ROSTB	URG :	MD	215	32		
MAR 31 1993	32. REGISTRAR'S	SIGNATURE							

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the intending physician.

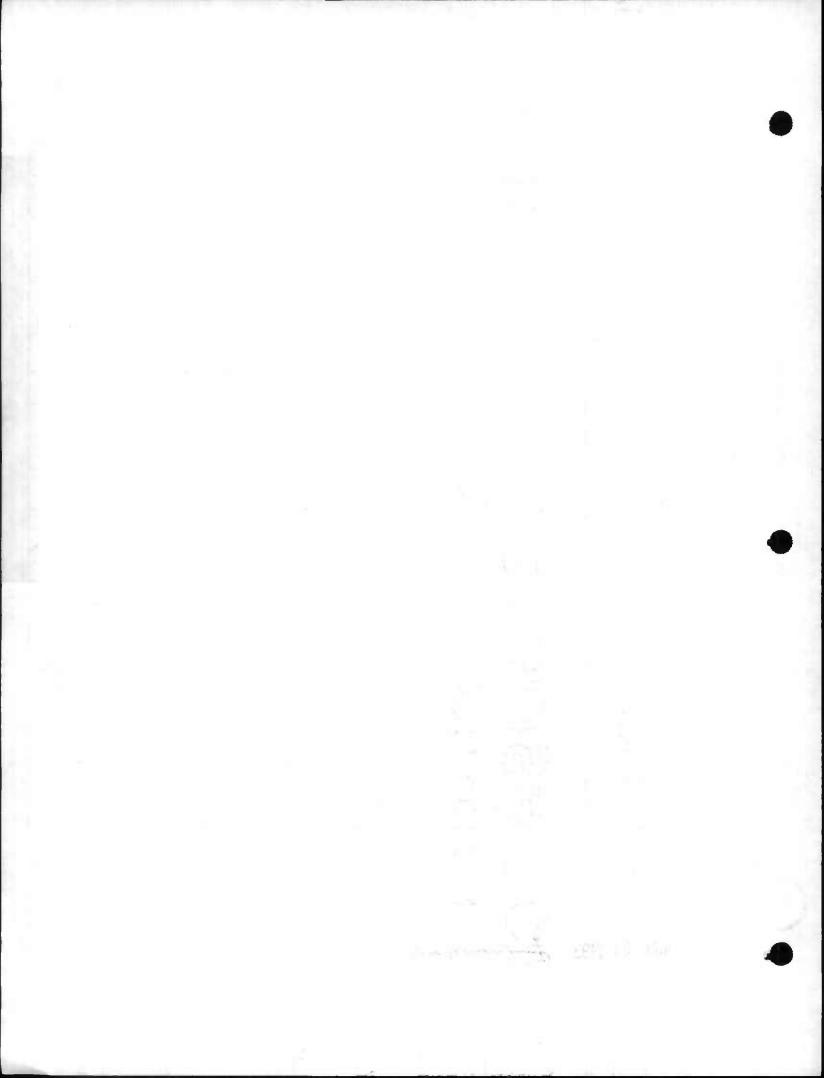
THE FUNERAL ORECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

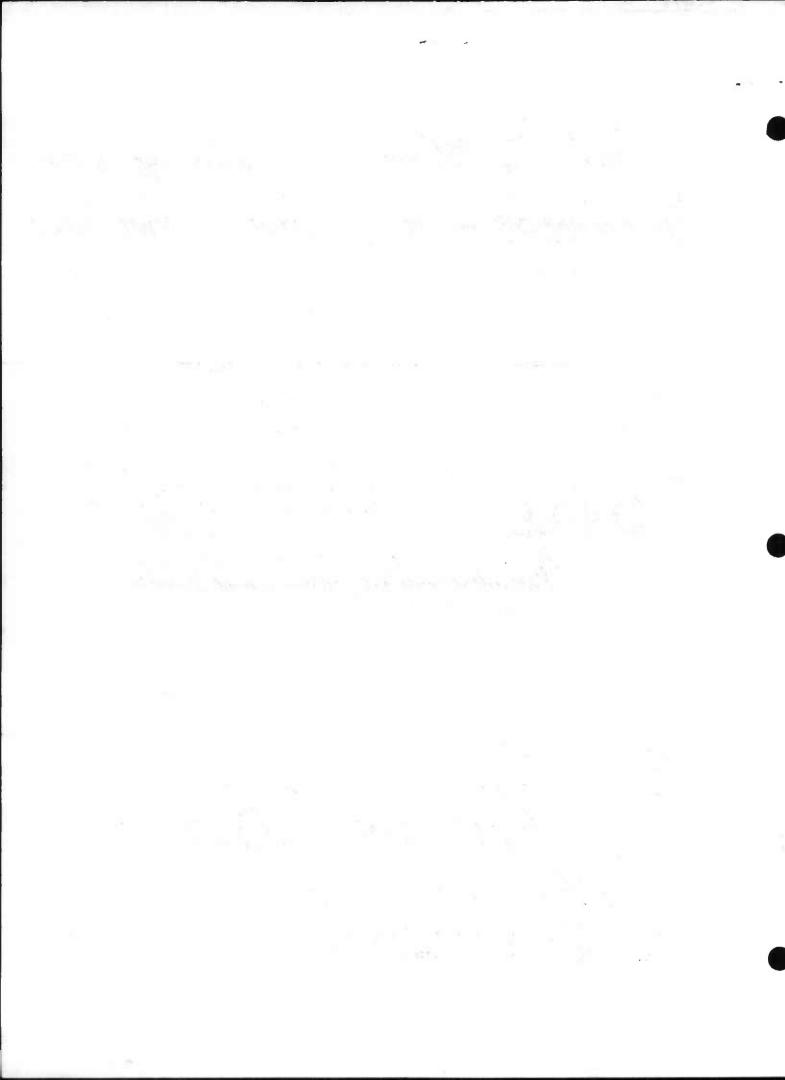
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



7	6	38	g g	23
OF VITAL	PHYSICIAN: The law	certificate has	the State Dep	, or item 23
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	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAN		TMENT OF H	EALTH AND DEATH		YGIENE REG. NO.				
	1. DECEOENT'S NAME (First, Middle, Last)	HE TAYM			2. DATE OF	DEATH DAY	- 93	AR 3. TIME OF DEATH M				
	4. SOCIAL SECURITY NUMBER 214-52-4150	OCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH						BIRTH	6. 8	HRTHPLACE (State or Foreign country) ryland		
TOR	90. FACILITY NAME (If not institution, give s SOUTHERN MAK RESIDENCE OF DECEDENT	SYLAND	HOSI	PITAL	9b. CITY, TOWN C	LINTO	EATH /		PRINC			
DIRECTOR	100. STATE 10b. COUNT Maryland Princ		y, town or locat	TION				10d. INSIDE CITY LIMITS? 1 YES 2 XXNO				
FUNERAL	100. STREET AND NUMBER 12200 Windbrook D	rive			101	20735		109. CITIZEN OF WHAT COUNTRY? United States				
B≺	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	S. ARMED 2 XX NO S	it yee, ap	CENDENT OF HISPA ecity Cuban, Mexic 2 XXNO Speci	en, Puerto Rica	RIGIN? (Specify Yea or No. 14, RACE - American I						
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		(Give kind of life. Do NOT us	USUAL OCCUPATION work done during mose retired.)	ON osl of working	16b. Kil	ID OF BUSIN	NESS/INDUST				
MP	6 0 Housewife 17. FATHER'S NAME (First, Middle, List) 18. MOTHER'S NAME (F								ne			
E C	Thomas Jenkins		ME (First, Midd) Smith		rname)							
TO B	19e. INFORMANT'S NAME (Type/Print)					and Number or Rural	Route Number, (City or Town,		/ (((),))		
	Vincent R. Tayman		W. 100							ille, Md.		
	20e, METHOD OF DISPOSITION AD Burlat 2 Cremation 3 Rem 4 Donation 5 Other (Specify)		cemeter St.	Y, COMBINE OF O	OF DISPOSITION (Na ther place) S Cemete	ry 03-18	B-93	DATE 20c. LOCATION — City or Town, State Piscataway, Maryland				
	Mg BNATURE OF FUNERAL SERVICE LIN	Brohawn		0053	22. NAME AF	ntt Fune	CILITY			, , mary rana		
	1 Jack 10 12	when			P.O.Bo	x 156, W	laldorf	, Mar	yland	20604		
	23. PART Lenter the diseases, or shock, or heart fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	List only one cau	se on each	ine.		peline, such				Approximate Interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	DUE TO	(OR AS A CO	ONSEQUENCE OF	F):							
L C	PART II. Other aignificant condition	a contributing to	deeth but	not reaulting	in the underlying	g ceuse given in	Part I. 24	. WAS AN AU	лорѕу	245. WERE AUTOPSY FINDINGS		
DC.							1[PERFORMI		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
. ME							_			1 Tes 2 No		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINERT	HOSPITAL:			OTHER:	ACE OF DEATH (CI						
HYS	27. MANNER OF DEATH	1 inpetient 2 inpetient 2 in 26e. DATE OF	INJURY	28b. TIM	E OF 28c. INJ				URY OCCURE	D		
BY F	1 Netural 5 Pending 2 Accident Investigation	2-2	1-9	3	M 1 🗆 1	YES 2 NO	fell					
	3 Sulcide 6 Could not be 4 Homicide determined	building,	etc. (Specify)	At home, term, a	In 95	Umm	281, LOCATIO	wn, State	Number or Ru	Med 20735		
COMPLETED		ICIAN: To the best of ER: On the basis of e								use(e) end manner ee stated.		
TO BE C	290. SUBJUATURE AND TITLE OF CENTINGS	mzuz	m	P		29 LICENSE NU	MBER 30	2	Pad. DATE SIG	NED (Month, Day, Year)		
	THOSE STOP PO	desue	2/	(ITEM 27) (Type)	Print) Ra	ypum	ch. Co	Sp.	M	20748		
	MAD 2 2 '93	W.C.	R'S SIGNATU	RE Bands H	, /					,		



3. TIME OF DEATH

2. DATE OF DEATH MONTH 3 - 14

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

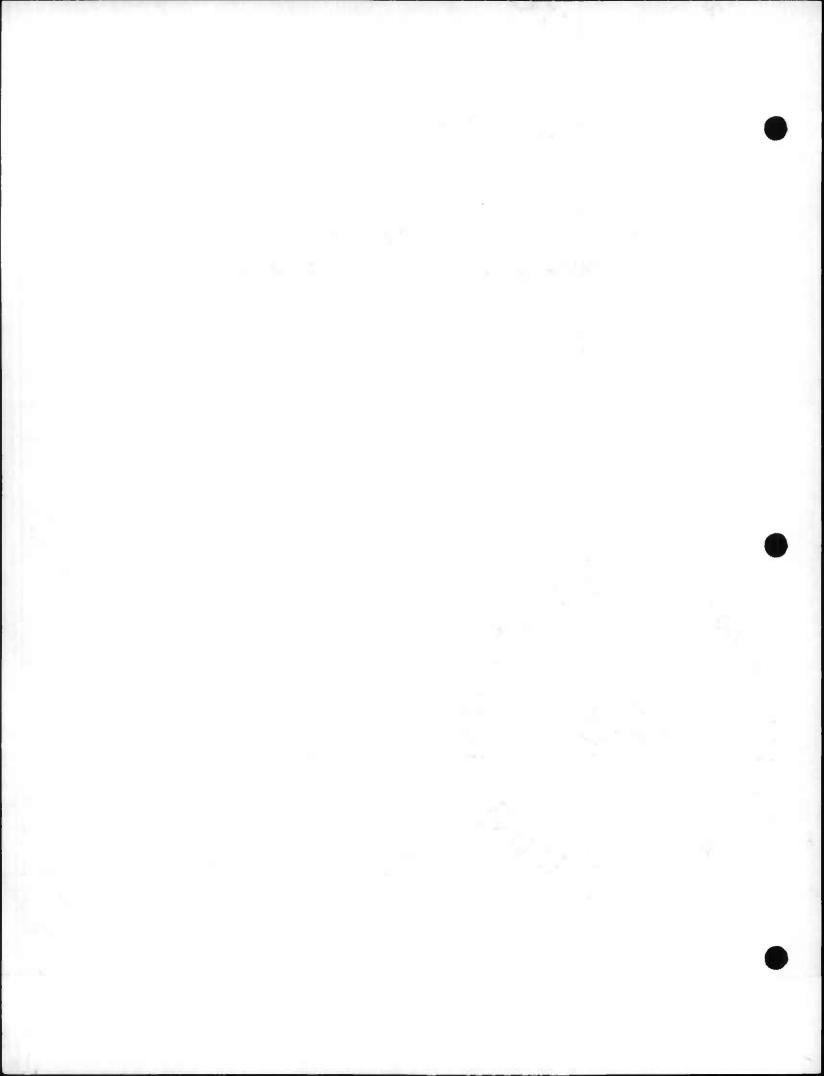
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стоя	Shady Grove	CEDENT		oital	1		tgomery					
DIRE	Maryland		tgomery		DAM				10d. II			NO
FUNERAL			ANITA	Terrac			208			Unit	n of what countr ted State	
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN FORCES? 11/2/YES IF YES, GIVE WAR OR DAI 1964-196			YYES 2 NO	ED 10	If yes, sp	CENDENT OF HISPA pecify Cuban, Mexic 3 2 NO Speci	an, Puerto R	IGIN? (Specify Yee or No— rto Rican, etc.) 14. RACE — American Black, White, etc. Specify: White			ndian,
PLETED		(0-12)		(Give	DENT'S USUAL kind of work don NOT use retired	e during m			ollege		TRY	
E COMPL	17. FATHER'S NAME (First, John Rand						18. MOTHER'S NA	AME (First, M	-	Surname)		
TO BE	190. INFORMANT'S NAME Patricia M	(Type/Print)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, C Same as 10							
	20a. METHOD OF DISPOSI 1	cemetery, creme	no pate of bisectory or other place	mato	ry	3-1			y or Town, State ring, Mar	ylan		
	22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring,									a Mn° and	210	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
MEDICAL C	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO									24b. WERE AUTOPS MAILABLE PR COMPLETION OF DEATH?	OF CAUSE	
AN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									1 🗆 YES 2	K NO	
SICI	EXAMINER?		HOSPITAL:	ER/Outpetlent 3	DOA 4 N	R:	174.7					
BY PHYS	27. MANNER OF DEATH 1 Netural 5 2 Accident	Pending Investigation	28a. DATE OF I (Month, De		28b. TIME OF INJURY M	Nursing Home 5				NJURY OCCURED		
	3 Suicide 8 4 Homicide	Could not be determined	28s. PLACE OF building, a	FINJURY — At home atc. (Specify)	e, farm, street, fa	ctory, offic	con .		(TION (Street a r Town, State)	nd Number or	Rural Route Number,	
COMPLETED			SICIAN: To the best of r									is stated.
TO BE (29b. SIGNATURE AND TITL 30. NAME AND ADDRESS (JH.	Esch	m.D.	7 (7 - Print)		DO	968	•	29d. DATE S	IGNED (Month, Day, Y	3
	31. DATE FILED (Month, Day	RH.	ESCH.	M, D,	10717	-5	tanmer	Dri	ve P.	tous	. md : 2	c859
- 10	(VI/A)-2 (() 9			idson Band							1	

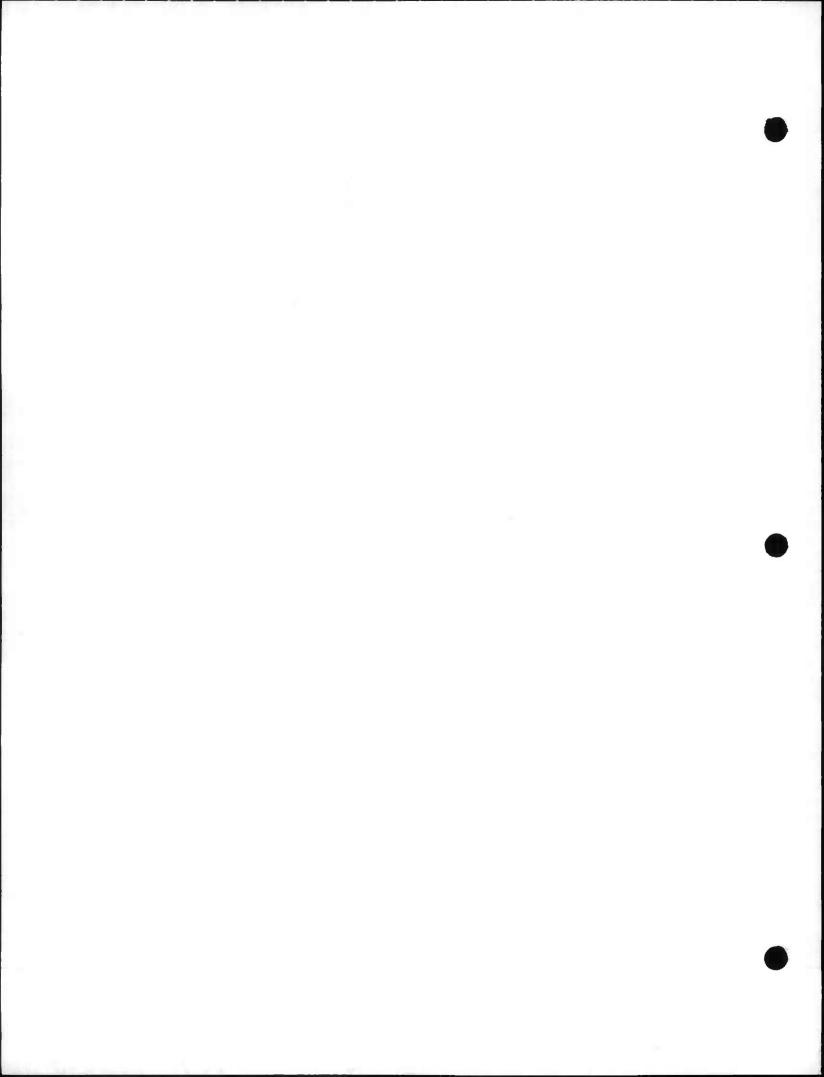
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

Jr.



OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	METION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
th. Page 6 may be retain	neral director, page 5 sho
thin 24 hours after dea	NERM. "RECTOR: After this certificate has been signed by the attending physician and completely filled in by the fur
lificate be executed wi	physician and comple
ires that the death cer	signed by the attending
SICIAN: The law requ	certificate has been
OH ATTENDING PHY	MRECTOR: After this
1	NERAL

		1 - STATE REGISTRAR	STATE OF MA	RYLAND /	DEPAR ERTIF	TMENT (OF HEA	LITH AND	MENTA	AL HYGIEN REG. NO.	E		
		1. DECEOENT'S NAME (First, Middle, Last	DECEOENT'S NAME (First, Middle, Lust) HELENED, TIMMICK 2. DATE OF OEATH MONTH DAY YEAR 73								TIME OF OEATH		
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. lest birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIR						E OF BIRTH	8.	BIRTHPLA	CE (State or Foreign	
		577-62-0570	OS DCC. 3, 190									Country) Mich	igan
	œ	9a. FACILITY NAME (If not institution, give						OCATION OF D	EATH		9c, COUNTY	OF OEATI	н
	ECTOR	Fernwood Nursing	g Home			Ro	ockvi	111e			Mont	gome	ry
	DIRE	10a. STATE 10b. COUN	10c. CIT	Y, TOWN OR	LOCATION	1				100	I. INSIDE CITY LIMITS?		
	AL D	1001 1	none		Wa	ashing		D.C.				23	YES 2 NO
ı	ERA	3601 Wisconsin A	AVe.N.W. #	510				0016					COUNTRY?
	FUNER	11. MARITAL STATUS	12. WAS OECEDENT E FORCES? 1		MED	13. WA	S DECENE	DENT OF HISPA	NIC ORIG	IN? (Specify Yes	US or No.— 14.	RACE -	American Indian,
	BY	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR	OR DATES	NO			y Cuben, Mexico NO Speci		Rican, etc.)		Specify:	
	60	15. OECEDENT'S ED			USUAL OCCI			16	b. KIND OF BUS		hite		
		(Specify only highest gra-	(G	Do NOT us			f working						
e .	COMPL			home	emaker					home			
at once.		17. FATHER'S NAME (First, Middle, Last) Stanley Bennett				10			Middle, Maiden	Surneme)			
fled	BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (S	Street and I			nney	n, State, Zio Coo	de)	
be notified	2	Robert B. Timmic	k							napoli			01
must b		20s. METHOD OF DISPOSITION 1 N Burlai 2 Cremation 3 Re	moval from State	20h PLACE	ANDDATE	E DISPOSITI	ON /Name /	of	0.4	TE 200 LO	CATION - CIN	or Town	State
E .		4 Donation 6 Other (Specify) 21, SIGNATURE OF FUNERIAL SERVICE I	ICENSEE 0 0 0	MoodT	awn (emete	Y AND A	Mar.1	5;93	Gra	nd Rap	ids,	Mich.
examiner		22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 2222 Wisconsin Ave., N.W., Wash., D.C.											
Icel e	\dashv	23. PARY i. Enter the diseeses, or	complications that co	nused the de	eath. Do n	ot enter th	22 W	iscons	in A	ve., N. I	W.,Was	h.,D	. C .
burial, cremation, or removal.		shock, or heart failure	. List only one cause	on each line).						atory arroad	'	Interval Between Onset and Death
event, the		disease or condition resulting in death)	a. RESPI	RAT	OR	4 1	LA	SLUI	RE				
even even			BOD O	AS A CONSE	OUENCE OF	7:							
traumatic	RTIFICATION	Sequentially list conditions, If any, leading to immediate b. ISRONCFIELTASIS DUE TO (OR AS A CONSEQUENCE OF):											
r trac	<u>8</u>	cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):											
other	쁘	that initiated events resulting in death) LAST	OUE TO (OF	AS A CONSE	ISEQUENCE OF): [NFECT								8
Injury, or other trac	빙		d								70		
- a	SP	PART II Other algorificant condition	ona contributing to de	ath but not r	esuiting i	n the unde	erlying ce	euse given in	Part i.	24a. WAS AN PERFOR		AM	RE AUTOPSY FINDINGS
shows en	MEDIC	GIVEMIN.							_	1 TYES 2	NO	OF	MPLETION DF CAUSE OEATH?
											'	1	YES 2 NO
Item 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		1		26. PLACE	OF DEATH (C/	heck only o	one)			
	HYSI	1 O YES 2 O	1 inpatient 2 EF					5 ☐ Residence					
Ked a	<u> </u>	Natural 5 Pending	28e. DATE OF INJ (Month, Day,		28b. TIM INJ	URY	Bc. INJURY WORK?		26d. DE	SCRIBE HOW IF	NJURY OCCUR	EO	
5 m	D BY	2	28e. PLACE OF IN	JURY — At ho	me, farm, s				261, LO	CATION (Street e	and Number or F	Rural Route	Number,
E 88	ETED	4 Homicide determined		· (upouny)					City	y or Town, State)			
The stand	SOMF.		SICIAN: To the best of my									ruse(s) and	d manner as stated.
2 M	TO BE	May you Com	ing MO	. fH	1SIC	IAN	29	D35	мвен 79	/	≥ 3	GNED (Mo	G3
	7	MERLYN VEW	URY 98	OF DEATH (ITE)	# 27) (Type EOR		Av	E, SI	CVE	En Spi	RING	, M	020902
		31. DATE FILEO (Month, Day, Year) MAR 19 '93	32. REGISTRAR'S	SIGNATURE	ndett								
L				-					_		_		DHMH-16 Rev 1/89



2. DATE OF DEATH DAY YEAR MARCH 16, 1993

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

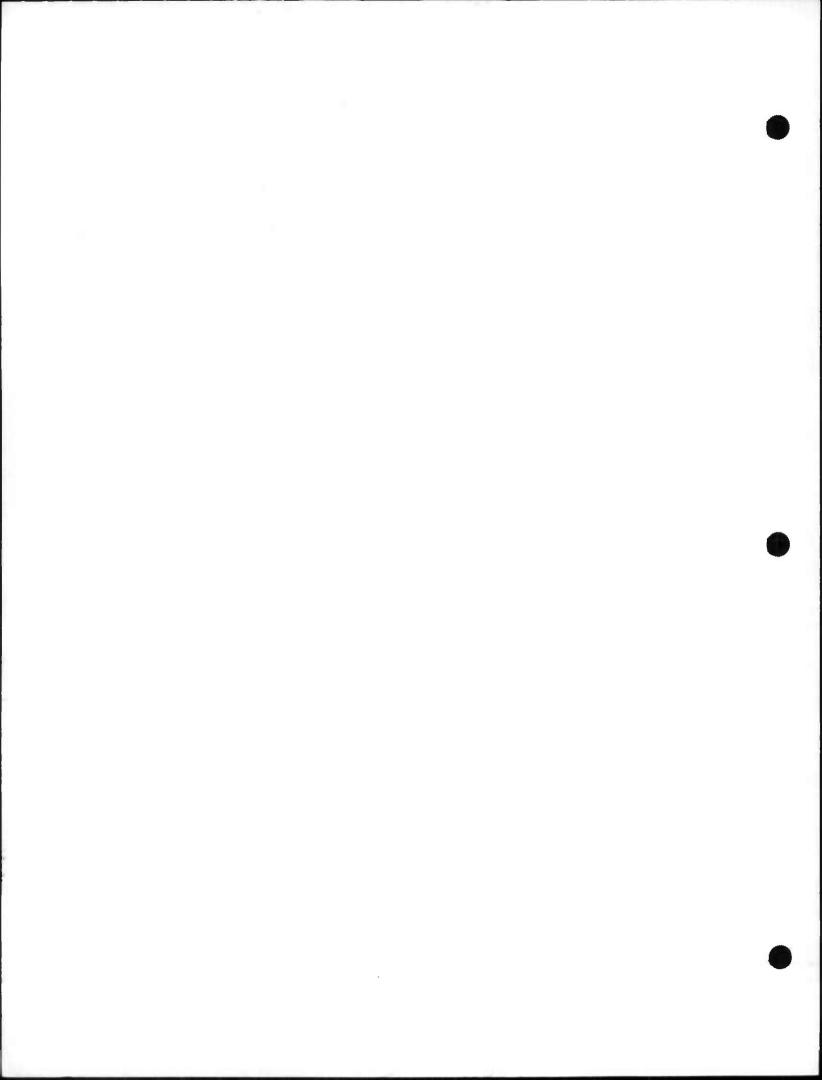
SYLVIA RUTH

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L RECORDS, P.O. BOX 68760	leath certificate be executed within 24
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RECC	requires that the c
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A	The
OF VITAL	PHYSICIAN:
VISION	ATTENDING PHYSICIA

	4. SUCIAL SECURITY NUM		S. SEX	or Frank (iii	yrs. last birthday)			F UNDER 24 HRS.	7. DATE OF BIR (Month, Day,		8. BIRTHPLACE (St Country)	nte or Foreign	
	578-28-8436 1□ M 2√ F		90 YRS. MONTHS DAY			MTS IN	NOV.17,190						
	90. FACILITY NAME (If not institution, give street and number		eet and number)							9c. COUNTY OF DEATH			
5	WI JON 1	YUMITH	r CARE CENTER			GA	the	esburg	7	M	Montgomery		
S C	10a. STATE	10b. COUNTY			10c. CI	TY. TOWN OR					104 100	CITY	
1 8	MARYLAND	MONTO	OMERV		CA	ттигро	יסווסי				LIMI	\$7	
			JOHERT		GF	TIUEK	_			10g, CITIZ			
ER/	301 RUSSELL	AVENUE	2				20	1877					
5	11. MARITAL STATUS		12. WAS DECEDEN			13. WA	S DECENE	DENT OF HISPAN	IIC ORIGIN? (Spec	olfy Yes or No-	14. RACE - Americ	an Indian,	
>	IF VES GIVE WAS OR D				ES					tc.)	Black, White, at Specify:	C.	
	A							E					
ETE	(Specify only highest grade completed)				(Give kind of	work done dun	JPATION ing most of	f working	18b. KIND	OF BUSINESS/INDI	JSTRY		
4	12	9-12)	Conege (1-4 or 5 4	')									
Ŏ.	17. FATHER'S NAME (First, M	fiddle, Last)			HOHLIN	KLK	18	. MOTHER'S NA	ME (First, Middle, I	Vaiden Surname)			
l iii	GEORGE L.				ROSA	DELL S	мттн						
0	19a. INFORMANT'S NAME (Type/Print)			19b. MAILIN	G ADDRESS (S	treet and f				Code)		
	MAX TRYON		(SON	1)	6008	NAMAKA	GAN	ROAD	BETHESD	A.MARYLA	ND 20816		
	1 X Burial 2 Crematic	on 3 🗆 Remo	val from State	20b. P	LACE AND DATE	OF DISPOSITION	ON (Name o						
			1/1			CEMETE			B/19 R	OCKVILLE	MONTGO	MERY	
	as: trame and address of Pacifill										ME INC		
	500 UNIVERSITY BLVD. W. STL. SPR. MD 209												
	23. PART i. Enter the d ahock, or h	iseasea, or co	ist only one cau	ceused t	tha death. Do	not anter th	e mode	of dying, such	as cerdiac or	reapiretory arre	et, App	roximate	
	IMMEDIATE CAUSE (Fir		11		1							rvai Betwee et end Dea	
	resulting in death)											141	
	DUE TO JOR AS A CONSEQUENCE OF):												
§													
§	ceuse. Enter UNDERLYING												
Ē	that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
	resulting in death) LAST												
	PART ii. Other algnifica	int conditions	contributing to	death but	not resulting	in the unde	rivina ce	suse given in	Part i 24a W	MS AN AITMOSY	245 WEDE AUG	DBCV EINDING	
₹					•	111/2/02	,	g	P	ERFORMED?	AWAILABLE		
밀									_ '''	rES 2 NO	OF DEATH		
≥									-		1 U YES	2 NO	
CIA	25. WAS CASE REFERRED TO						28. PLACE	OF DEATH (Che	ck only one)				
					_	QT/HER:							
	EXAMINER?		HOSPITAL: 1 Inpatient 2	ER/Outpat	lent 3 🗆 DOA		Home 5	Residence	6 Other (Specia	y)			
YSI	1 TYES 2 NO 27. MANNER OF/DEATH			INJURY	28b. Til	4 Nursing	c. INJURY			HOW INJURY OCC	JRED		
YSI	1 VES 2 NO 27. MANNER OF/DEATH 1 Netural 6		1 Inpatient 2 I	INJURY iy, Year)	28b. Till IN	4 X Nursing	c. INJURY WORK?			,,	JRED		
BY PHYSI	1 YES 2 NO 27. MANNER OF/DEATH 1 Natural 6 2 Nocident 3 Suicide 6	Pending Investigation Could not be	1 Inpatient 2 Inpa	INJURY iy, Year)	28b. Till IN	4 X Nursing	c. INJURY WORK?	AT	28d. DESCRIBE	HOW INJURY OCCI	JRED or Rural Route Numb	ж,	
BY PHYSI	1 YES 2 NO 27. MANNER OF/DEATH 1 Netural 6 2 Nocident 3 Suicide 6 4 Homicide	Pending Investigation Could not be detarmined	28a. DATE OF (Month, Date of building,	INJURY ny, Year) F INJURY — atc. (Specify	28b. Till IN. - At home, farm,	4 Nursing Ner OF 28 JURY M 1 street, factory,	c. INJURY WORK? L YES	AT 2 NO	28d. DESCRIBE 281. LOCATION (City or Town,	HOW INJURY OCCI Street and Number of State)	or Rural Route Numb)ç	
BY PHYSI	1 YES 2 NO 27. MANNER OF/DEATH 1 Natural 6 2 Occident 3 Suicide 6 4 Homicide 298. CERTIFIER (Check only)	Pending Investigation Could not be detarmined	28s. DATE OF (Month, Did building, Date of Mar. To the best of	INJURY iy, Year) F INJURY — atc. (Specify my knowled	At home, farm,	4 Nursing RE/OF 28 JURY M 1 street, factory,	c. INJURY WORK? I YES office	AT 2 NO NO place, and due	281. LOCATION (City or Town,	HOW INJURY OCCI	or Rural Route Numb		
BY PHYSI	1 YES 2 NO 27. MANNER OF/DEATH 1 Netural 6 2 Nocident 3 Suicide 6 4 Homicide 29a. CERTIFIER (Check only one) 2 MEDI	Pending Investigation Could not be detarmined FIFYING PHYSIC ICAL EXAMINER	28a. DATE OF (Month, Date of building,	INJURY iy, Year) F INJURY — atc. (Specify my knowled	At home, farm,	4 Nursing RE/OF 28 JURY M 1 street, factory,	c. INJURY WORK? I YES office	AT 2 NO NO place, and due	281. LOCATION (City or Town,	HOW INJURY OCCI	or Rural Route Numb		
COMPLETED BY PHYSI	1 YES 2 NO 27. MANNER OF/DEATH 1 Natural 6 2 Occident 3 Suicide 6 4 Homicide 298. CERTIFIER (Check only)	Pending Investigation Could not be detarmined FIFYING PHYSIC ICAL EXAMINER	28s. DATE OF (Month, Did building, Date of Mar. To the best of	INJURY iy, Year) F INJURY — atc. (Specify my knowled	At home, farm,	4 Nursing RE/OF 28 JURY M 1 street, factory,	c. INJURY WORK? WORK? YES office	AT 2 NO NO place, and due	28d. DESCRIBE 28t. LOCATION (City or Town, to the cause(a) at	HOW INJURY OCCI Street and Number of State) Individual of the control of the con	d. cause(s) and menr		
BE COMPLETED BY PHYSI	1 YES 2 NO 27. MANNER OF/DEATH 1 Netural 6 2 Nocident 3 Suicide 6 4 Homicide 29a. CERTIFIER (Check only 0ne) 2 MEDI 29b. SIGNATURE AND TITLE	Pending Investigation Could not be determined IFYING PHYSICICAL EXAMINER	28a. DATE OF (Month, Di 28e. PLACE OI building,	INJURY ny, Yoar) F INJURY — atc. (Specify my knowled camination a	28b. Till 180 - At home, farm,	4 Nursing	c. INJURY WORK? WORK? YES office	2 NO	28d. DESCRIBE 28t. LOCATION (City or Town, to the cause(a) at	HOW INJURY OCCI Street and Number of State) and manner as state- ice, and due to the	or Rural Route Numb d. cause(s) and menr	or as stated.	
COMPLETED BY PHYSI	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 6 2 Nocident 3 Suicide 6 4 Homicide 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	Pending Investigation Could not be determined TIFYING PHYSICICAL EXAMINER OF CENTIFIER	28a. DATE OF (Month, Di 28e. PLACE OI building, AN: To the best of ax COMPLETED CAUS	INJURY ny, Your) F INJURY — atc. (Specify my knowled camination a	At home, farm,	4 Nursing BFOF 28 BFOF 18 Street, tactory, M 1 street, tactory, and at the time	c. INJURY WORK? WORK? Soffice office deta and ion, death	AT 2 NO place, and due occured at the	28d. DESCRIBE 28l. LOCATION (City or Town, to the cause(e) as time, data and pla BER	HOW INJURY OCCI	d. cause(s) and menr	or as stated.	
BE COMPLETED BY PHYSI	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 6 2 Nocident 3 Suicide 6 4 Homicide 29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	Pending Investigation Could not be detarmined TIFYING PHYSIC CAL EXAMINER OF CENTIFIER PERSON WHO RUG9 S	28a. DATE OF (Month, Di 28e. PLACE OI building,	INJURY - atc. (Specify my knowled amination a	28b. Till IN At home, farm, In At home, farm, In At home, farm, If ge, death occur In (ITEM 27) (Type	4 Nursing BFOF 28 BFOF 18 Street, tactory, M 1 street, tactory, and at the time	c. INJURY WORK? WORK? Soffice office deta and ion, death	AT 2 NO place, and due occured at the	28d. DESCRIBE 28t. LOCATION (City or Town, to the cause(a) at	HOW INJURY OCCI	d. cause(s) and menr	or as stated.	
	AN: MEDICAL CERTIFICATION TO BE COMPLETED B	PART II. Other algnifications of the survival	99. FACILITY NAME (If not institution, give structure) PRESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MARYLAND MONTO 10c. STREET AND NUMBER 301 RUSSELL AVENUE 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Lest) GEORGE L. SMITH 19a. INFORMANT'S NAME (Type/Print) MAX TRYON 20a. METHOD OF DISPOSITION 1 Widerial 2 Cremetion 3 Remoded December 1 December 1 December 2 December 2 December 2 December 2 December 3 December	PROPERTY NAME (If not institution, give street and number) WITCH AND HOLD CARL RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY MARYLAND MONTGOMERY 10e. STREET AND NUMBER 301 RUSSELL AVENUE 11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 FYES, GIVE M. 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 - 12) 17. FATHER'S NAME (First, Middle, Last) GEORGE L. SMITH 19e. INFORMANT'S NAME (Type/Print) MAX TRYON (SON 20e. METHOD OF DISPOSITION 10. Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. BIOMATURE OF PIPERAL SERVICE LICENSE 23. PART I. Enter the diseases, or complications that shock, or heart failure. List only one cau immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) NOULT TO DUE TO CAUSE (Pinel disease) PART II. Other significant conditions contributing to DUE TO CAUSE (Disease or injury that initiated events resulting in death) LAST 25. WAS CASE REFERRED TO MEDICAL	99. FACILITY NAME (If not institution, give street and number) PRESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MARYLAND MONTGOMERY 10c. STREET AND NUMBER 301 RUSSELL AVENUE 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last) GEORGE L. SMITH 19a. INFORMANT'S NAME (First, Middle, Last) GEORGE L. SMITH 19a. INFORMANT'S NAME (First, Middle, Last) 20b. Rethol of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 21. SECHETIAL SERVICE LICENSEE 23. PART I. Enter the diseases, or complications that caused to ahook, or heart failure. List only one cause on accomplete disease or condition resulting in death) NOTED TO (OR AS A Complete Security of the course. Enter UNDERLYING CAUSE (Pinel disease or injury that inhitated events resulting in death) LAST AND DUE TO (OR AS A Complete Security of the course. Enter UNDERLYING CAUSE (Disease or injury that inhitated events resulting in death) LAST AND DUE TO (OR AS A Complete Security of the course of the course. 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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnal-transit permit. Pages 1, 2, 3 should be filled with the State Dept. of Health and Mental Hygiene prior to burnal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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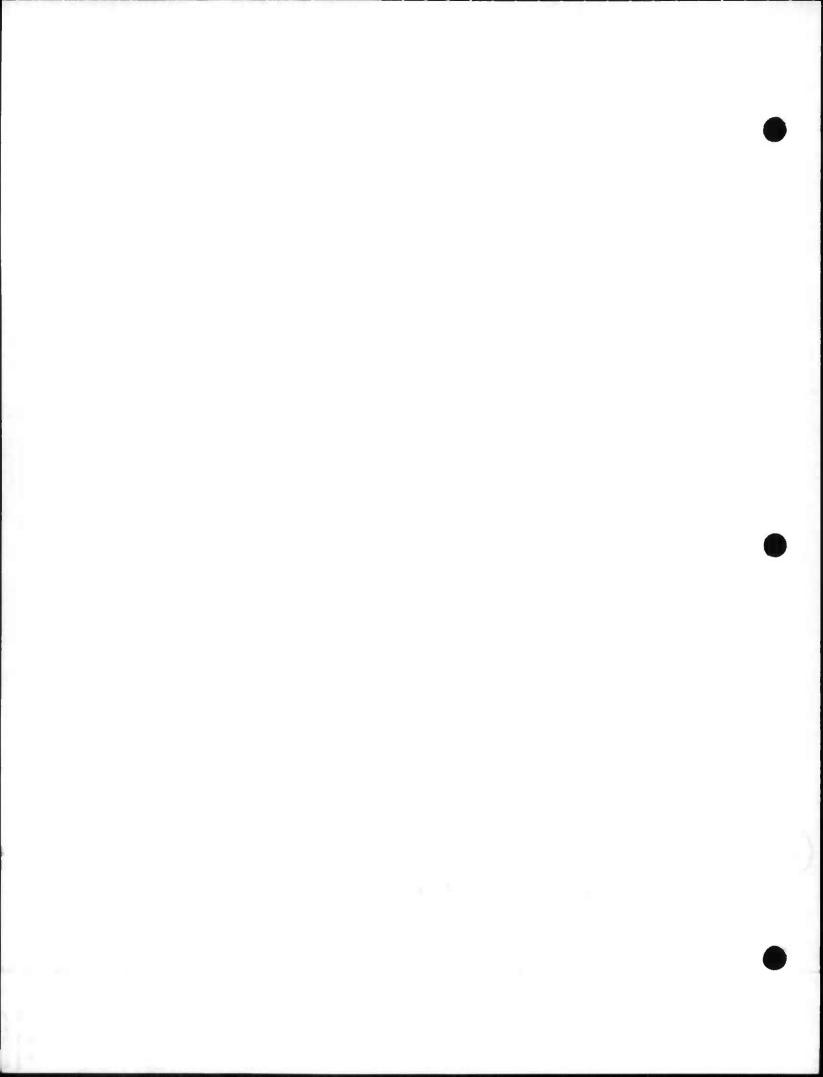
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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		FOR 1 - STATE REGISTRAR		STATE OF I	MARYLA		DEPART					IENT/	AL HYGIEN REG. NO.	E	3	00010
	- 5	1. DECEDENT'S NAME (First	, Middle, Last)						-				E OF DEATH			3. TIME OF DEATH
				Evelyn	Luci.	lle	Tyre	e				Mai	rch 15,	1993	3	1:00 P W
		4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In	yrs. last		F UNDER 1 Y	EAR MAYS	IF UNDER	24 HRS.	7. DATI	E OF BIRTH			PLACE (State or Foreign
ᄝ		203-74-7724		1 M 2 F	44		YRS.				72"	Dec		1948		ginia
2, 3 should	TOR	9a. FACILITY NAME (If not in 7509 Bren RESIDENCE OF DEC	ish Dı	rive				Gait				ATH .			ntgor	
Pages 1	DIRECTO	10e. STATE Maryland	Montgo	omerv				thers								10d. INSIDE CITY LIMITS? 1 YES 2 NO
sit permit.	FUNERAL (100. STREET AND NUMBER 7509 Bren							_	ZIP CODE		.087	, o	1	ZEN OF WI	HAT COUNTRY?
cian. Htran	3	11. MARITAL STATUS	1011 011	12. WAS DECEDEN	T EVER IN	U.S. ARM	IED	13. WA	S DECE	NDENT O		_	IN? (Specify Yes			tates American Indian
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, 2, notified at once.	B	1 Never Married 2 3 Widowed 4 Divo		FORCES?	YES	2 XN		If yo	88, spe	cify Cubar	n, Mexican. Specify:	, Puerto	Rican, etc.)		Specify	- American Indian, White, atc. '' hite
215 atten		15. DEC (Specify onl	EDENT'S EDUCA	ATION ompleted)		(G/v	EDENT'S U	rk done duri	JPATIO	N t of workin	ю	16	b. KINO OF BUS	SINESS/IND	USTRY	
21 Vital or d for u	COMPLETED	Elementary/Secondary (6		College (1-4 or 5		life.	Do NOT use	retired.)			•		Hair	Colon		
ANE hosp detache	N N	17. FATHER'S NAME (First, M	licicila (.ast)			CUSI	netol	Jyrsc		10 MOTH	AEO'S NAM	F (F)-4	Middle, Meiden		!	
YL/		Unavailab									avail			Surnemej		
MARYLAND retained by the hospit 5 should be detached notified at once.	BE	19a. INFORMANT'S NAME ()				196.	MAILING /	DORESS (S	itreet an				nber, City or Town	n, State, Zip	Code) #	203
M, Me Letter Se retter Se	2	Angela Wils	son										er Spr			
IORE, e 6 may be ector, page		20e. METHOD OF DISPOSIT 1 Buriel 2 Crematic 4 Donation 5 Other	on 3 🗆 Remov	val from State	20b. I came	LACEA	ND DATE OF	DISPOSITIO	ON (Nan	ne of		DA	TE 20c. LO	CATION —	City or Tow	rn, Stats
Page I direc		21. SIGNATURE OF FUNERA		NSEE	2	UDUI	nan	22. NA	ME ANI	DADDRES	SS OF FAC	ILITY				g, Maryland
BALTIMORE, after death. Page 6 may be by the funeral director, page moval. ical examiner must be a		· Ele	en (U.K	ap	0							rices, <u>S</u> ilver			MD 20910
B hours after of in by the or removal		23. PART I. Enter the d	Iseeses, or co	emplications the	it caused	the dec	th. Do no	t enter th	e mod	le of dyl	ng, such	as ca	rdiac or respi	ratory arm	est,	Approximate
T of It		IMMEDIATE CAUSE (Fir		ist only one cat	use on eac	on ane.										Interval Between Onset and Death
五 金 是 。		disease or condition	→ a.	Pneum	onia			ial)								6 days
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OX Clan Brown to the re-	ATI	if any, leading to imme cause. Enter UNDERLY	diate	H I V												
m 2 4 2 m	IFIC	CAUSE (Disease or Inju- that initiated events	iry C.	DUE TO	(OR AS A	CUL	JENCE OF):									-
0. 6 5 6	CERTIFICATION	resulting in death) LAS	T d.													
0 4 4 5 2	=	PART II. Other significa	int conditions	contributing to	death bu	t not re	sulting in	the unde	rlying	cause g	iven in P	art 1.				WERE AUTOPSY FINDINGS
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RECOR requires that seen signed to of Health an shows any		Colitis,	Sinusi	tis								_				1 YES 2 NO
E 25. 000	Ä	Neutropen:														
/ITA N: The Scale h State 0	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO		HOSPITAL:				THER:			EATH (Chec	Ť				
OF VI. PHYSICIAN: this certifical with the St.	HYS	27. MANNER OF DEATH		1 Inpatient 2 28a. DATE OF	INJURY	tient 3	28b. TIME	OF 28	Home				er (Specify) SCRIBE HOW II	NJURY OCC	CURED	
NO OF IND PHYS seth with marked,	ВУ Р		Pending Investigation	(Month, E	Day, Year)		INJU	TY	WOF	RK? ES 2						
S 2 2 2 #		3 Suicide 6	Could not be determined	28e. PLACE (building,	OF INJURY - atc. (Specif	Al hon	ne, farm, str	set, factory,	office			281. LO C/h	CATION (Street a or Town, State)	and Number	or Rural Ro	oute Number,
DI ATTE DIRECTO Hours afti	J.E	29a. CERTIFIER 1 X CERT	TIFYING PHYSIC	IAN: To the best of	f my knowle	dge, des	th occurred	at the time	data :	and place	and due t	o the co	susse(s) and mar	oner ee stets	ed.	
C New Y	COMPLETED															and manner es stated.
TO THE HOSPING TO THE FUNES THE SIGN WITHIN THE MINDORTANT.	TO BE (296, SIGNATURE AND TITLE KATHOUNE	Wall	mau	01	1.]				29c. LICE	SE HUME	SER 3		29d. DATE	SIGNED (Month, Day, Year)
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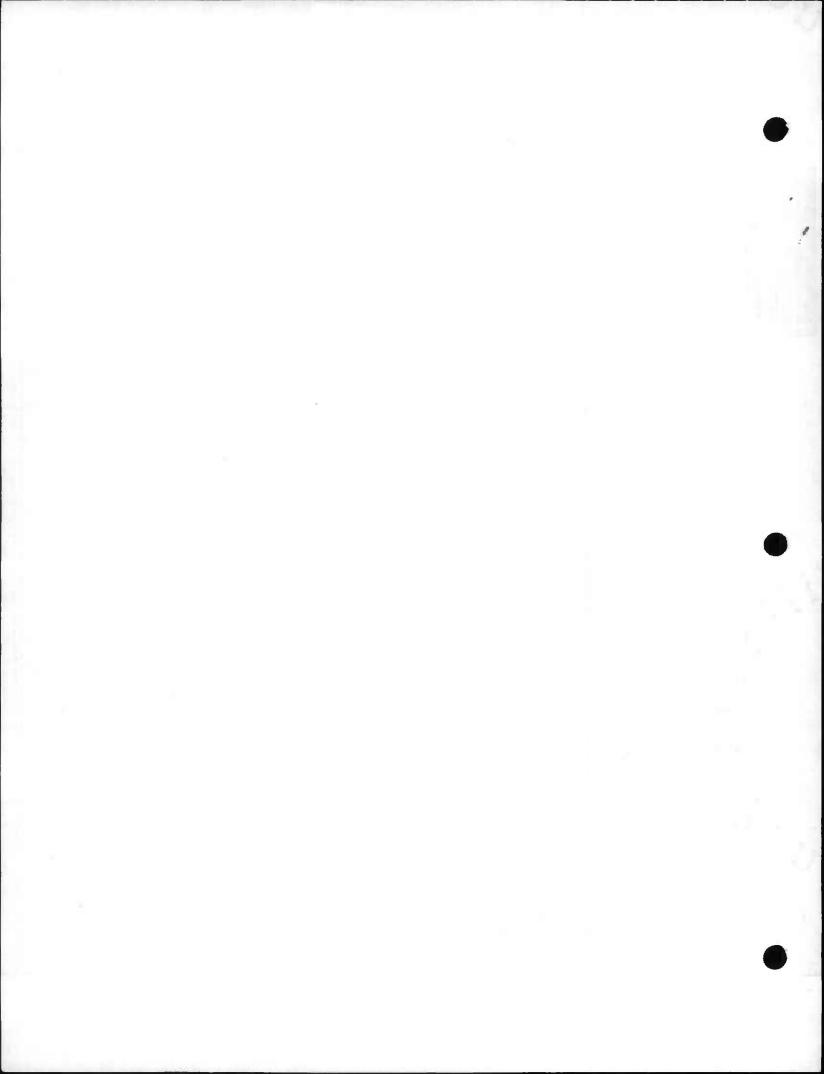
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	JRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages.		
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH red T nsky YEAR (1)101 March 12,1993 10:30 PM M A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign (Morth, Day, Year) March 22,895 579-58-0600 98 1 M 2 X F Mississippi 9a. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN 5805 Queens Chapel Road DIRECTOR Hyattsville Prince George RESIDENCE OF DECEDEN 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY none none Washington D.C. 13 YES 2 | NO FUNERAL 10s, STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2122 Massachusetts Ave., N.W. 20008 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 😾 Never Married 2 🔲 Married BY 3 Widowed 4 Divorced white COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) tax specialist I.R.S. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTNER'S NAME (First, Middle, Maiden Sumame) unavailable unavailable 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Robert A. Gazzola 1730 K St., N.W., Washington, D.C. 20a. METHOD OF DISPOSITION
1 M Burlai 2 Cremation 3 Rec 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Cedar Hill Cemetery Mar. 19, 93 4 Donation 5 Other (Specify) Suitland, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF EACILITY
Devol Funeral Home 2222 Wisconsin Ave., N.W., Washington, DC 23. PART I. Entar the diseases, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory erreat, Approximate ahock, or haert failure. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF); atterosclarotic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO Becent Pheumania COMPLETION OF CAUSE 1 TES 2 10 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATN (Check only one) **EXAMINER?** HOSPITAL: OTHER:

Nursing Nome 5 Residence 8 Other (Specify) 1 YES 2'NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d. OEȘCRIBE NOW INJURY OCCUREO 1 Distural 5 Pending 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, term, street, fectory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Yown, State) 3 Sulcide 6 Could not be BE COMPLETED 4 Homicide CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the besia of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 379 CIN D St 3 3 93 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

7500 Greenway

Center Drive Greenbelt MD 20770



BALTIMORE, MARYLAND 21215-0020

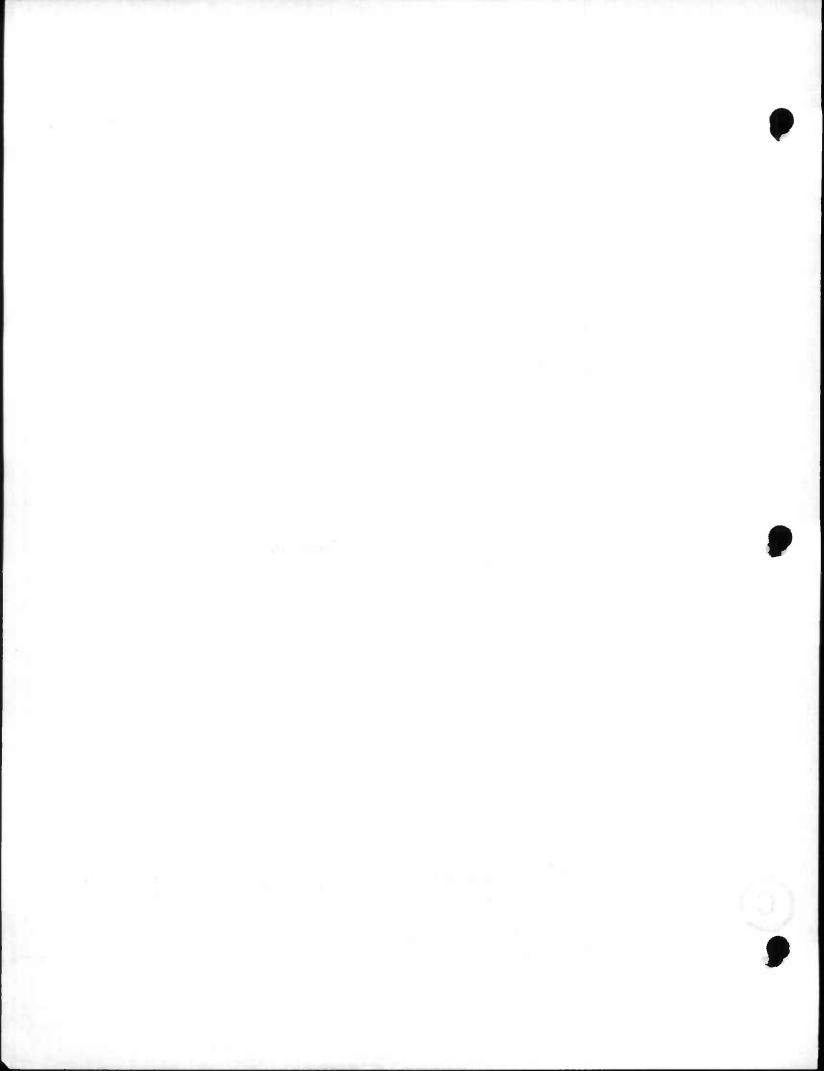
DIVISION OF VITAL RECORDS, P.O. BOX 6876'

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR	CE	:HITH	CATEO	F DEATH	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) KATHRYN BROOKS T	ALL				2. DATE OF DEATH DO	"15 9".	3. TIME OF DEATH 3 OS AM
	4. SOCIAL SECURITY NUMBER 5. SEX 1 □ M 2 1 F	8. AGE (In yrs. last		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH Dec. 4,19	16	BIRTHPLACE (State or Foreign Country) Georgia
	9a. FACILITY NAME (If not institution, give elreet and number)		9	b. CITY, TOWI	OR LOCATION OF DI	EATH	9c. COUNTY	OF DEATH
DIRECTOR	Potomac Valley Nursing H	Ome		Rockv	ille		Montg	gomery
H	10a. STATE 10b. COUNTY		10c. CITY, 1	TOWN OR LOC	ATION			10d. INSIDE CITY LIMITS?
	Maryland Montgomery		Betl	hesda				TES 2 NO
FUNERAL	100. STREET AND NUMBER 10320 Westlake Dr. #3	06E			01. ZIP CODE 20817			OF WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried FORCES? 1 3 ½ Widowed 4 Divorced IF YES, GIVE V	T EVER IN U.S. ARI YES 2 (X) N WAR OR DATES	MED O	If yes,	ECENDENT OF HISPAI specify Cuben, Mexice ES 2 NO Specif		or No- 14.	RACE — American Indian, Black, White, etc. Specity: White
<u>a</u>	15. DECEDENT'S EDUCATION	16a, DEC	CEDENT'S US	UAL OCCUPA	TION	18b. KIND OF BUS	SINESS/INDUS	
	(Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4 or 5	(Gh	ve kind of worl Do NOT use n	k done during i etired.)	nost of working			
COMPLETED	4		e eco	nomist		Nation	al Geo	ographic
ō.	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Meiden		
BE	Fuller H. Brooks				Ma	ggie Grisw	old	
2	19e. INFORMANT'S NAME (Type/Print)	19b				Route Number, City or Town		
-	Jan D. Fahlgran		10320) West	lake Dr.,	Bethesda,	Md. 20	817
	20s. METHOD OF DISPOSITION 1	20b. PLACE A cemetery, cren Metro	ND DATE OF I	pisposition (Name of Matory M	ar.15,93 A	cation – city	or Town, State
	21. SIGNATURE OF PUNERAL SERVICE LICENSEE	1.0		22. NAME	AND ADDRESS OF FA	CILITY		zza, va.
	· John F. De	let		2222	l Funeral Wisconsin	Ave., N.W.	,Wash.	,D.C. 20007
		se on each line.	477 C		ANCE		ratory arrest	Approximete Interval Between Onset and Death
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	(OR AS A CONSEO	UENCE OF):					
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is	HOSPITAL	ER/Outpatient 3	DOA 4	THER:	me 5 - Residence	8 Other (Specify)		
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending (Month, D 2 Accident Investigation	INJURY my, Year)	28b. TIME O	9F 28c, II	IJURY AT PORK? YES 2 NO	28d. DESCRIBE HOW II	NJURY OCCUR	ED
	3 Suicide 28e. PLACE O	F INJURY At hon atc. (Specify)	ne, ferm, stre	et, tectory, of	Ice	281. LOCATION (Street e City or Town, Stete)	and Number or F	Rural Route Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of examiner: On the best of examiner:							suse(e) end manner se stated.
O BE		KE MI			29c. LICENSE NUN DC 49		29d. DATE SI	GNED (Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CALL						/	
	James Kane, M.D., 4910 M		etts A	Ave.,N	.W.,Washi	ngton, D.C	. Suit	:e 304
		AVIDAGE A	ndell.					



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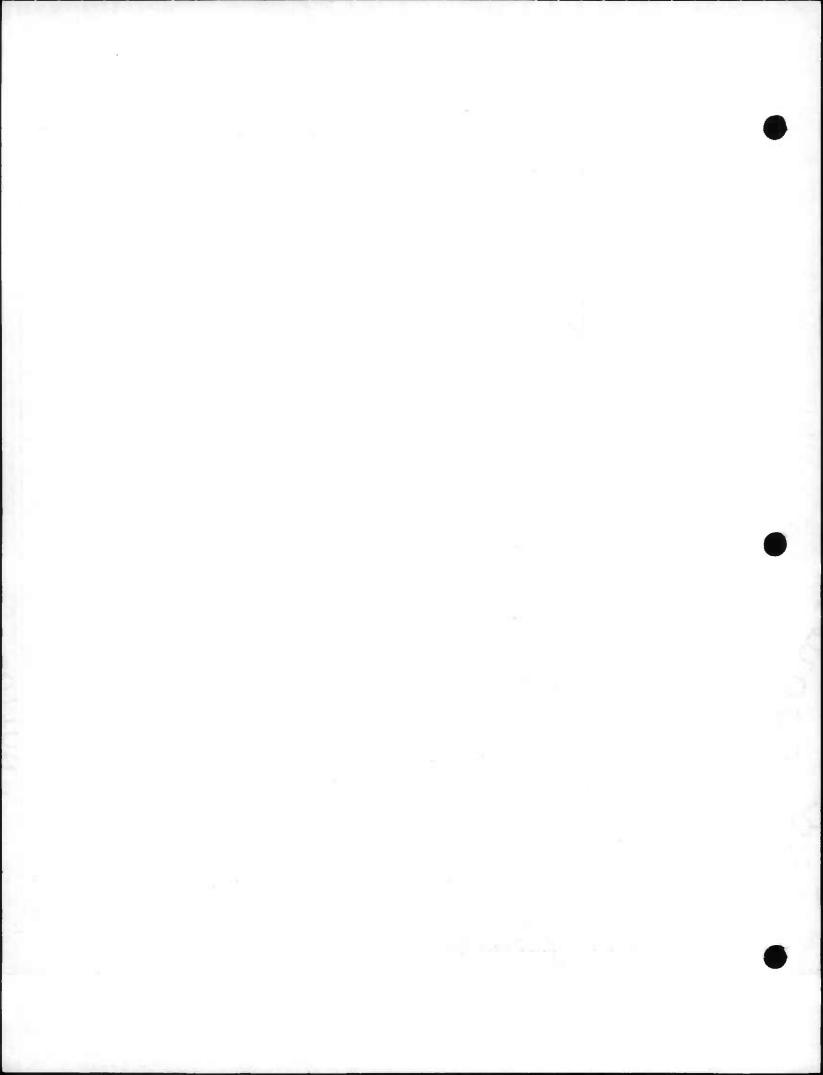
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NO ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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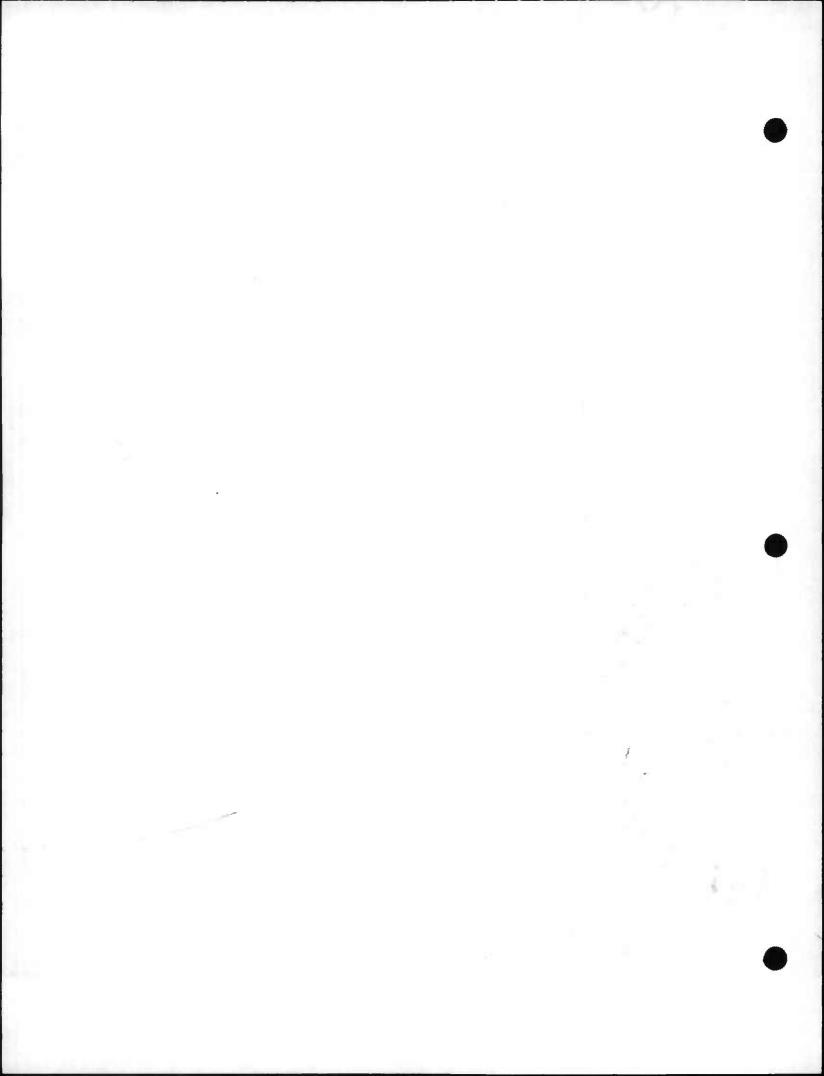
93 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1/DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 0415 HOMPGO. 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year vrs. Inst hirthday) IF UNDER 1 YEAR Washington, DC 579-40-3123 9s. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Temple Hills 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 4504 Cedll Place 20748 United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 X NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify: Black BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KING OF BUSINESS/INDUSTRY 12th lary (0-12) College (1-4 or 5+) Baker Safeway Groceries 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) William C. Thompson Mary Louise Anderson BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Thompson 4504 Cedell Pl., Temple Hills, MD. 20748 20s. METHOD OF DISPOSITION
1X Burlel 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Maryland National Cemetery 3/11 Laurel, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Alexander S. Pope Funeral Home 5538 Marlboro Pike, District Hts. MD 2074 erse 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Betw **IMMEDIATE CAUSE (Finel Onset and Death** disease or condition nestamuel resulting in death) (OR AS A CONSEQUENCE OF) MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY 1 TYES 2 LINE OF DEATH? 1 TES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINERY

VES 2 NO 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inputient 2 | ER/Outputient 3 | DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNEB OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1- Netural 5 Pending Investiga 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 _ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	
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	1 - STATE REGISTRAR			FICATE O		MENTAL HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, La JOSEPH		, III			2. DATE OF DEATH MONTH DATE OF DEATH DATE OF DATE OF DEATH DATE OF DATE	YEAR	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 578-68-3488	5. SEX 6. AGE	(In yrs. last birthday)	F UNDER 1 YEAR	7	7. DATE OF BIRTH 7 (Month, Ony, Year) 7 6 5	8. BIRT	HPLACE (State or Foreign		
	9e. FACILITY NAME (If not institution, gh		12 YRS.		OR LOCATION OF D		9c. COUNTY OF	h.,D.C.		
8	PRINCE GEORGES H	,		CHEVERL		EATH	PRINCE C			
ן בֿ	RESIDENCE OF DECEDENT 10a. STATE 10b. COU		44.00	TY, TOWN OR LOC						
DIRECTOR	D.C.	N/A	17	Washin				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?		
ER	6140 Banks	Pl., N.E.			20019		U.S	S.A.		
BY FUNERAL	11. MARITAL STATUS 1.X Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 ☑ YES IF YES, GIVE WAR OR E	2 NO	If yes,		NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) y:		E - American Indian, ik, White, etc.		
9	15. DECEDENT'S E (Specify only highest gr	DUCATION	16a. DECEDENT'S	S USUAL OCCUPA work done during i	TION most of working	16b. KIND OF BUS	SINESS/INDUSTRY			
LET	Elementary/Secondary (0-12) 12th	College (1-4 or 5 +)	Iffe. Do NOT u	borer		Constr	uction			
COMPL	17. FATHER'S NAME (First, Middle, Last)		L	OTET	18. MOTHER'S NA	ME (First, Middle, Maiden				
w	Joseph T. I	urner,Jr.				tha M. D	,			
0 B	19a. INFORMANT'S NAME (Type/Print)				t end Number or Flural	Route Number, City or Tow				
-	Bertha M. Tur				# 10 abo					
	1X Burial 2 Cremation 3 R	emoval from State Car	b. PLACE AND DATE	other place!		1	CATION — City or T			
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	larmony	22. NAME	AND ADDRESS OF FA	1/93 Lan	dover, N	ia.		
	Namy	N. Pra	ut-	49	o.wasnir 25 Burro	igton & S oughs Ave	.,N.E.	•		
CERTIFICATION	disease or condition resulting in death) s. Multury are failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST LAST FAILURE (DISEASE) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
10 II		d.								
MEDICAL	PART II. Other significant condit		but not resulting			PERFOR	AUTOPSY 24	b. WERE AUTOPSY FIND AVAILABLE PRIOR TO		
MEDICAL		HOSPITAL:		28.	PLACE OF DEATH (C)	PERFOR	AUTOPSY 24	D. WERE AUTOPSY FIND AWAILABLE PRIOR TO COMPLETION OF CAL OF DEATH?		
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	HOSPITAL: 1) Inpatient 2 ER/Out 26e. DATE OF INJURY (Month, Day, Year)	Ipatient 3 DOA	28. OTHER: 4 — Nursing Ho		PERFOR	AUTOPSY 24 IMED?	D. WERE AUTOPSY FIND AWAILABLE PRIOR TO COMPLETION OF CAL OF DEATH?		
TED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	HOSPITAL: 1) Inpatient 2 ER/Out 26e. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY (Month, Day, Year)	ipatient 3 □ DOA 28b. Tili IN.	OTHER: 4 Nursing Ho ME OF 28c. II	PLACE OF DEATH (Cr ome 5 Residence NJURY AT YORK? YES 2 NO	PERFOR 1 VES 2 veck only one) 6 Other (Specify)	AUTOPSY 24 IMED? NO NO	b. WERE AUTOPSY FINE AMALABLE PRIOR TO COMPLETION OF CAI OF DEATH? 1 YES 2 NC		
BY PHYSICIAN: MEDICAL	PART II. Other significant conditions and the significant conditions are conditionally as a significant condition and the significant conditions are conditionally as a significant condition and conditional conditions are conditionally as a significant conditional conditional conditions are conditional con	NOSPITAL: 1 Inpatient 2 ER/Out 26e. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, atc. (Spe 1 INTER: On the basie of examination	ipatient 3 DOA 28b. Tili IN Y — At home, ferm, scify) wiedge, death occurron end/or investigati	28. OTHER: 4 Nursing Home OF Jac. Hill Home OF Jac. Hill Home Of J	PLACE OF DEATH (CF ome 5 Residence NJURY AT VORK? VES 2 NO Notice Ite end place, end due, death occurred at the	PERFOR 1 VES 2 1 VE	AUTOPSY MED? NO NO NO NO NO NO NO NO NO NO NO NO NO N	AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO		
ETED BY PHYSICIAN: MEDICAL	PART II. Other significant conditions and the significant conditions are conditionally as a significant condition and the significant conditions are conditionally as a significant condition and the significant conditions are conditionally as a significant conditional conditional conditions are conditionally as a significant conditional conditional conditional conditional conditions are conditional c	HOSPITAL: 1) Inpetient 2 ER/Out 26e. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, atc. (Spa IYSICIAN: To the best of my know INER: On the basic of examination FIER WHO COMPLETED CAUSE OF DE	Ipatient 3 DOA 28b. Tih IN Y— At home, ferm, scily) wiedge, death occur on end/or investigati	28. OTHER: 4 Nursing No ME OF 28c. If JURY M 1 streel, factory, off	PLACE OF DEATH (Cr ome 5 Residence NJURY AT YORK? YES 2 NO Ilice Ite end place, end due death occured at the	PERFOR 1 VES 2 Peck only one) 6 Other (Specify) 28d. DESCRIBE HOW I City or Yown, State) 1 to the cause(s) end man I tima, date and place, an	AUTOPSY MED? NJURY OCCURED and Number or Rural due to the cause. 29d. DATE SIGNE MULL MULL AUTOPSY 24 AUTOPSY AU	D. WERE AUTOPSY FIND AVAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO		
BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other significant conditions and the significant conditions are conditionally as a significant condition and the significant conditions are conditionally as a significant condition and conditional conditions are conditionally as a significant conditional conditional conditions are conditional con	HOSPITAL: 1) Inpetient 2 ER/Out 26e. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, atc. (Spa IYSICIAN: To the best of my know INER: On the basic of examination FIER WHO COMPLETED CAUSE OF DE	Ipatient 3 DOA 28b. Tih IN Y— At home, ferm, scily) wiedge, death occur on end/or investigati	28. OTHER: 4 Nursing No ME OF 28c. If JURY M 1 streel, factory, off	PLACE OF DEATH (Cr ome 5 Residence NJURY AT YORK? YES 2 NO Ilice Ite end place, end due death occured at the	PERFOR 1 VES 2 reck only one) 6 Other (Specify) 28d. DESCRIBE HOW I City or Yown, State) 1 to the cause(s) end man tima, date and place, an	AUTOPSY MED? NJURY OCCURED and Number or Rural due to the cause. 29d. DATE SIGNE MULL MULL AUTOPSY 24 AUTOPSY AU	D. WERE AUTOPSY FINE AMAILABLE PRIOR TO COMPLETION OF CAL OF DEATH? 1 YES 2 NO Route Number, e) end manner as state D (Month, Day, Year)		



DHMH-18 Rev 1/89

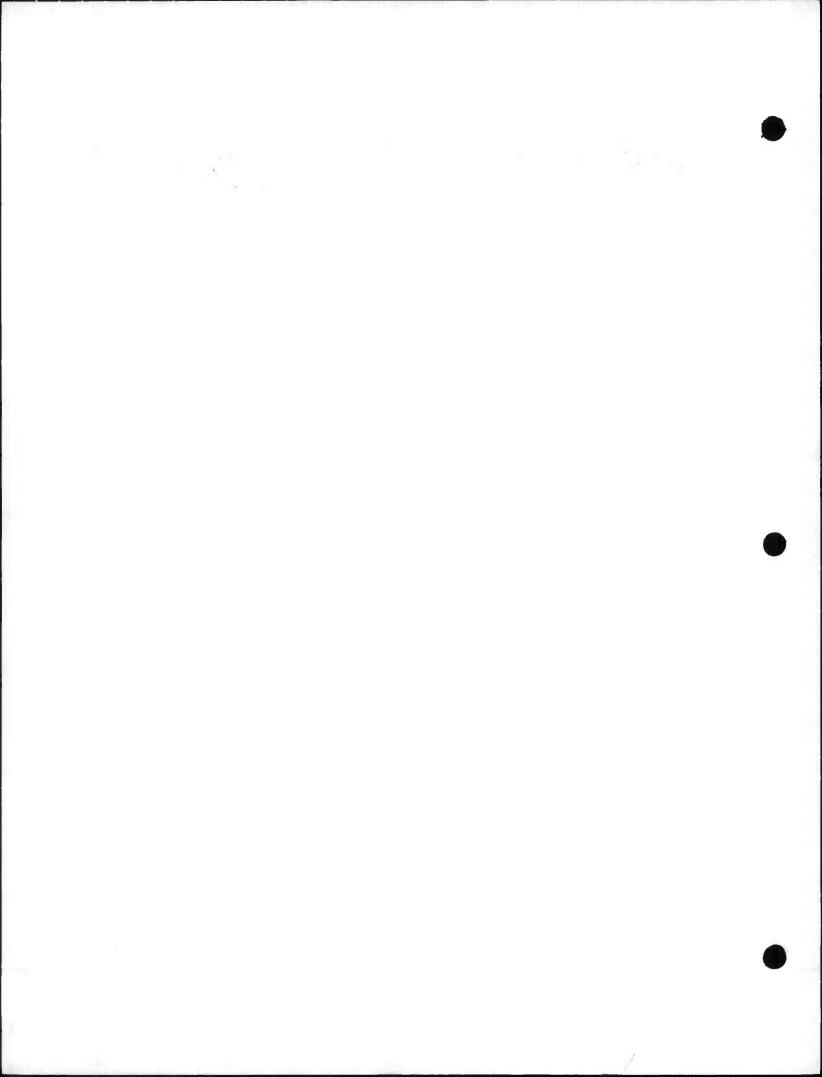
FOR STATE REGISTRAR

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1 1	1. DECEDENT'S NAME (First, Middle, Last)	DAVID FRANC	TS THODN	TON /		2. DATE C			OF DEATH			
	Trancis		1 hos	nta		MONTH 3	10 DAY 7	3ª 06	59			
	2/420-1358	1 M 2 D F 3	yrs fast birthday) YRS.		DAYS HOURS MIN.	7. DATE O	PRITH 35	a. BIRTHPLACE (Si Country) MARYLAN				
20	90. FACILITY NAME (If not institution, give stree ANNE ARUNDEL MEDI RESIDENCE OF DECEDENT				POLIS	DEATH /	Action to the second se	NNE ARUN	DEL			
DIMECTOR	10s. STATE 10s. COUNTY	ARUNDEL		Y, TOWN OR NNAPO			10d. INSIDE CITY LIMITS? 1 YES 2 NO					
VENAL	10e. STREET AND NUMBER 29 WEST WASHINTO	N STREET			101. ZIP CODE 21401			109. CITIZEN OF WHAT COUNTRY? U.S.A.				
BY FUNEH	11. MARITAL STATUS 1 Arever Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DA	2 X 140	13, Wi	AS DECENDENT OF HISPI yes, specify Cuban, Mexic YES 2 XXIO Spec	ANIC ORIGIN? can, Puerto Ri sily:	(Specify Yes or No— can, etc.)	14. RACE — Ameri Black, White, e Specify:	en Indian, c.			
	15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12)		16a. DECEDENT'S (Give kind of the Do NOT us LABOR	work done du se retired.)	CUPATION ring most of working	16b. (KIND OF BUSINESS/INC	BLACK				
LABORER 17. FATHER'S NAME (First, Middle, Last) UNOBTAINABLE UNOBTAINABLE												
2	UNOBTAINABLE 19a. INFORMANT'S NAME (TyperPrint) DR. DOROTHY CHAMBERS 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 1/2 HICKS AVENUE ANNAPOLIS, MD. 21401											
	20a. METHOD OF DISPOSITION 1	rai from State cem PII	PLACE AND DATE OF STREET, Crematory or ONELAWN M	of disposit	ON (Name of ARK 3/16/	0ATE	20c. LOCATION — ANNAPOL					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Havy J. Less 22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 2140											
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A DORSEQUENCE OF):											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	2/1/	4									
	PART II. Other significant conditions	contributing to death be	outing to death but not reaulting in the underlying cause given in P					COMPLET OF DEATH	PRIOR TO ON OF CAUS ?			
• 1	25. WAS CASE REFERRED TO MEDICAL EVALUATED 28. PLACE OF DEATH (Check only one)											
	EXAMINER?	HOSPITAL:		OTHER:		■ 8 □ Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED						
	EXAMINER? 1	HOSPITAL: Impettent 2 ER/Output 28a. OATE OF INJURY (Month, Day, Year)	28b. TIM	4 🗆 Nursir	ng Home 5 Residence 8c. INJURY AT WORK? 1 YES 2 NO	_	100000	CURED				
TED BY PHY	EXAMINER? 1 YES 2 NO 1 27. MANNER OF DEATH	28s. OATE OF INJURY	28b. TiM INJ	4 Nursir E OF 2 URY M	ng Home 5 Residence 8c. INJURY AT WORK? 1 YES 2 NO	28d. DESC	100000		er,			
TED BY PHY	EXAMINER? 1 YES 2 NO 1 MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide a Could not be detarmined 29a. CERTIFIER (Check only)	28s. OATE OF INJURY (Month, Day, Year) 28s. PLACE OF INJURY	28b. TiM INJ — At home, farm, s	4 Nursir E OF 2 URY M 2 street, factor	ng Home 5 Residence Sc. INJURY AT WORK? 1 YES 2 NO y, office	28d. DESC 28f. LOCAT City or	FION (Street and Number Town, State)	or Rural Route Numb				
TO BE COMPLETED BY PHYSICIAN:	EXAMINER? 1 YES 2 NO 1 MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide a Could not be detarmined 29a. CERTIFIER (Check only)	I inpatient 2 ER/Output 28a. OATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Special Place) Special Place Spe	At home, farm, sidedge, death occurring and/or investigation	4 Nursir E OF 2 URY M 2 street, factor	ng Home 5 Residence Sc. INJURY AT WORK? 1 YES 2 NO y, office	28d. DESC 28f. LOCAl City or	TION (Street and Number Town, State) e(a) and manner as state and place, and due to the	or Rural Route Numb	ner aa stated			

MAR 1 6 1993 Julia Tavidron Bondage

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



BALTIMORE, MARYLAND 21215-0020

Annual Amerithms certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should have been signed by the attended to the annual Hygiene prior to burial, cremation, or removal. of ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE De fled

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	1 - STATE REGISTRAR	STATE OF I	/ MARYLAND CE	DEPAR	RTMEN'	T OF H	EALTH	AND I	MENTAL	HYGIEN	E		
3	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	OF DEATH	_		3. TIME OF DEATH
- 0	William	L.	Tho	omas					момтн	12	199	93 ^{YEAR}	2:40A
Į.	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER	R 1 YEAR	IF UNDER	24 HRS.	7. DATE (OF BIRTH		8, BIRTH	IPLACE (State or Foreign
	216-56-1347	1 💢 M 2 🗆 F	41	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)			Countr	γ)
	9e. FACILITY NAME (If not institution, give s.	treet end number)			9b. CITY	r, TOWN O	R LOCATE	ON OF DE				Maryland JNTY OF DEATH	
E.	Memorial Hospita	1 at Fac	ton										Carr
DIRECTOR	Memorial Hospita	I at Eas	COII		L E	stor	1				Ta.	1bot	
)H	10e. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCATION										10d. INSIDE CITY
	Maryland (Caroline	е				\mathbf{F}	ede:	rals	burg			LIMITS?
FUNERAL	10e. STREET AND NUMBER					101.	ZIP CODE						VHAT COUNTRY?
ᇤ	3622 I	epper 1	Road					2	1632		U	.S. I	A .
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13.	WAS DECI	ENDENT C	F HISPAN	VIC ORIGIN	(Specify Yee	or No-	14. RACE	— American Indian,
ВУ Б	1 Never Married 2 XMerried 3 Widowed 4 Divorced	IF YES, GIVE W	YES 2XN	10		If yes, spe 1 YES			n, Puerto A	ican, etc.)			white, etc. White
													will be
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DE	CEDENT'S ive kind of a Do NOT us	USUAL O	CCUPATIO	N st of workin	10	16b.	KIND OF BUS	INESS/IN	DUSTRY	
٣	Elementary/Secondary (0-12)	College (1-4 or 5 -	Hat	che.	retired.)	aho	ror	-			Pou	1try	7
₹	7th			CIIC	- <i>I</i> -	Jabo							
	17. FATHER'S NAME (First, Middle, Last)	Dwoote	. Ml	_						iddle, Maiden		,	
BE		Prestor						_		y Ham			
2	190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip C 3622 Pepper Rd., Federal Sburg.										p Code)		
-	11-1-11, 1-11-12, 112										21632		
	20a, METHOD OF DISPOSITION 1 12 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)											City or To	
	4 Donatton 5 Other (Specify) Bloomery Cemetery									Nr.	Fe	dera	lsburg,MI
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Framptom-Hawkins-Eskow Funeral Ho												
E \$	Muchael +	· Tskew	•		1 1	ram	ptor	n−Ha 13	awk1	ns-Es	KOW	Fun	eral Home
	PO Box 43, Federalsburg, MD 21632 23. PART i. Enter the diseases, or complications that ceueed the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate												
	snock, or heert failure. Liet only one cause on each line.											interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	Sex	otic	56	DOK								Onset and Death
	DUE TO (OR AS A CONSEQUENCE OF):												
-	Retis Observated abores												
ō	Sequentienty hat conditions, DUE TO (OR AS A CONSEQUENCE OF):												
8	cause. Enter UNDERLYING												
CERTIFICATION	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
토	resulting in death) LAST												
- 10	DADT II Osbar alguldiana and dala												
¥	PART II. Other aignificant condition	a contributing to	death but not re	asuiting	in the un	nderlying	ceuse g	jiven in	Part i.	24s. WAS AN . PERFOR	AUTOPSY MED?	24b.	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
ă	Deabotes	neums	5						_	1 YES 2	NO		COMPLETION OF CAUSE OF DEATH?
ME													1 _ YES 2 _ NO
ż												- 1	
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:					ACE OF D	EATH (Ch	eck only one)			
YSI	1 TYES 2 NO	1 Øvinpatient 2 □	ER/Outpatient 3	□ DOA	OTHER 4 - Nun		5 🗆 Re	sidence	8 🗆 Other	(Specify)			
PHYSICIAN: MEDICAL	27. MANNER OF DEATH	28e. DATE OF (Month, Da		28b. TIM	E OF URY	28c. INJU	JRY AT		28d. DE\$6	CRIBE HOW I	JURY OC	CURED	
B	1 Natural 5 Pending 2 Accident Investigation				М		ES 2	NO					
	3 Sulcide 8 Could not be	28e. PLACE Of building.	F INJURY — At horetc. (Specify)	me, ferm, a	street, tect	lory, office			281, LOCA	TION (Street e	nd Numbe	r or Rural A	oute Number,
COMPLETED	4 Homicide determined		100			1			, 0	, 01010)			
1	290. CERTIFIER (Check only	CIAN: To the best of	my knowledge, der	nth occum	ed at the t	lme, date	end place.	end due	to the cour	e(e) end man	ner ee ate	ted.	
S	one) 2 MEDICAL EXAMINE												end manner as stated.
	29b. SIGNATURE AND TITLE OF GERTIFIER			-			29c. LICE						
8	1/- 1 1 () 0,00	wo				- 1		PATY	-		290. DAT		(Month, Day, Year)

296. SIGNATURE AND TITLE OF GERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

29c. LICENSE NUMBER 031749

21601

29d. DATE SIGNED (Month, Day, Year)

3/12/93

503 Dutch Easton 31. DATE FILED (Month, Day, Year)

,03 5

32. REGISTRAR'S SIGNATURE hia Davidson-Randsell

DHMH-16 Rev 1/89

should

TO THE HOSPITAL OF TO THE FUNERAL DISPORTANT. If IN

2

30. NAME AND ADDRE

11/0 31. DATE FILED (Month, Play, Year)

ERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print)

32. REGISTRAR'S SIGNATURE

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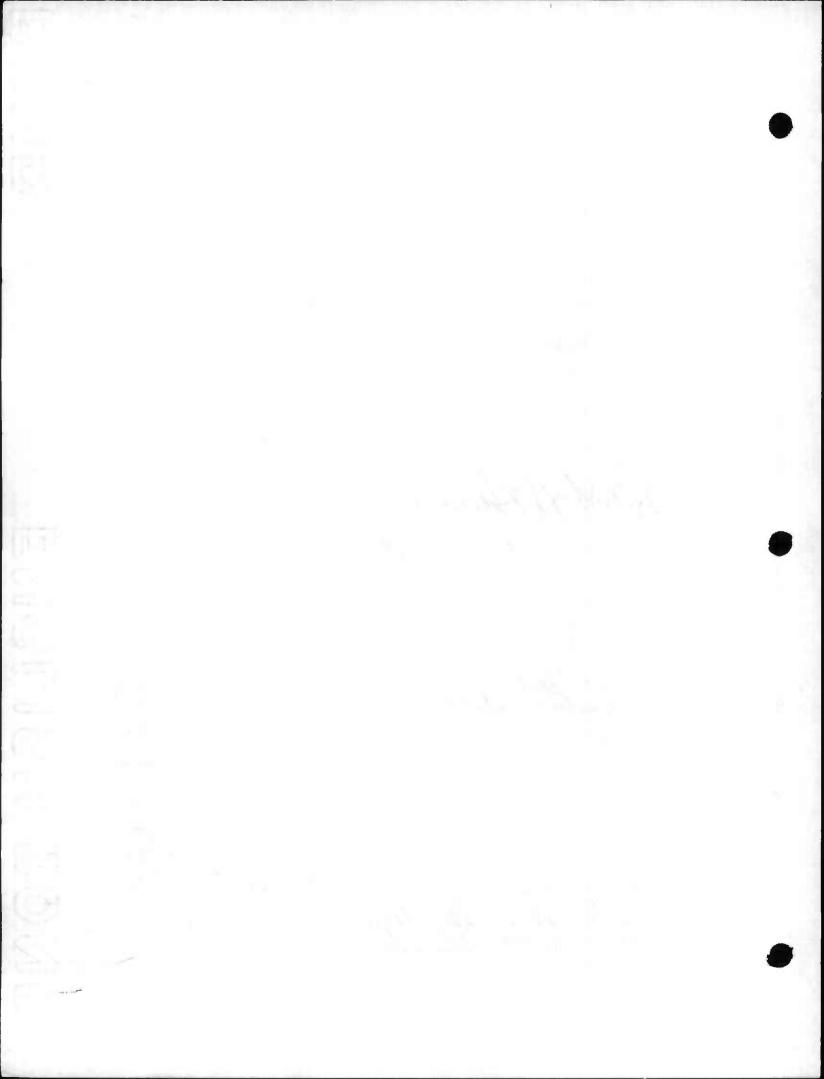
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which transfer - Ra

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	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pag		
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SIGNAT. THE INT. INC. INC. DESIGNATION OF STREET, INC. INC. INC. INC. INC. INC. INC. INC.	peen	the State Dept. of Health and Mental Hyglene prior to burial. cremation, or removal.	, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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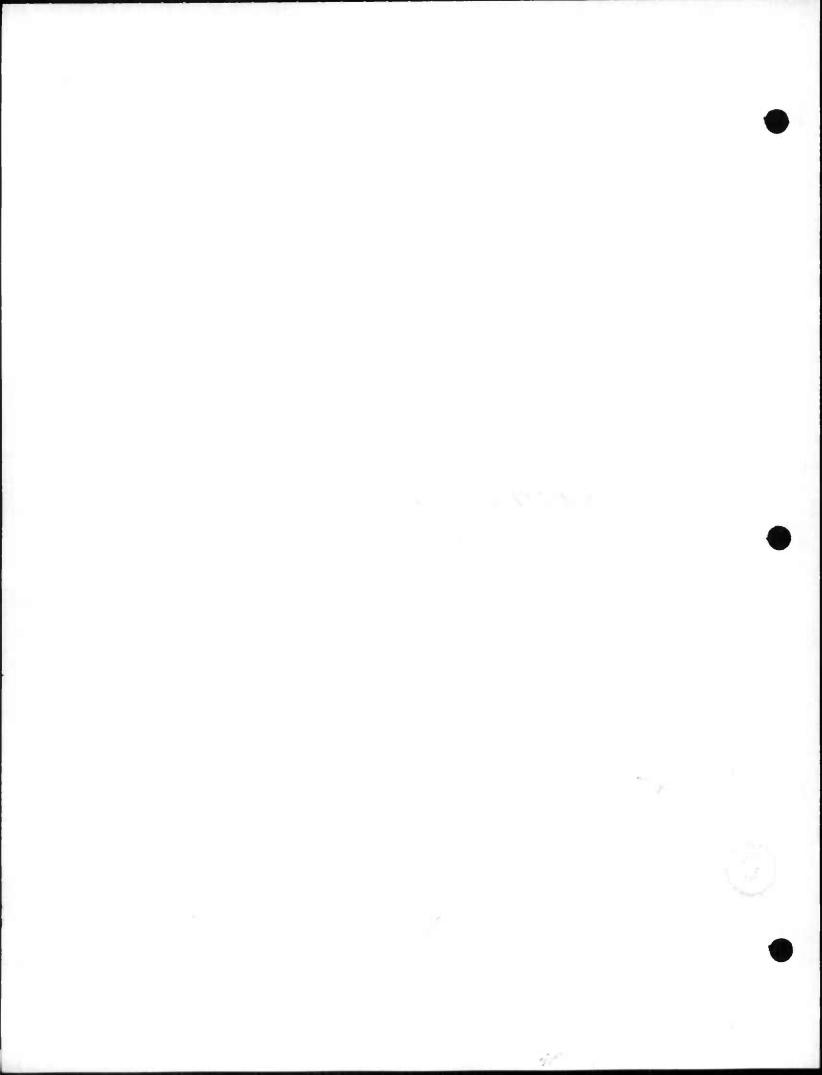
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 11, MARGARET IRENE THUM 1991 March 9:00 AM 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year, 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 1 M 2 F YRS. 220-09-9168 74 1919 Feb. 6, Maryland 9e. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR COFFMAN NURSING HOME Hagerstown Washington RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 X YES 2 | NO Washington Maryland Hagerstown FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Coffman Nursing Home 21740 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ANO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 X Never Married 2 Merried Specify. White 1 YES 2 XNO Specify: BY 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Harlan Thum Bessie Duke BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 9 Public Square Sharon Turner Hagerstown, Maryland 21740 20e. METHOD OF DISPOSITION
1 1 Duriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name 20c. LOCATION - City or Town, State DATE 1 Buriel 2 Cremetion 3 4 Donation 5 Other (Specify) netary crematory o Rose Cemetery 3-12-93 Hagerstown, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximata interval Between ahock, or heart fallure. List only one IMMEDIATE CAUSE (Final Onset and Death Sho disease or condition DUE TO (OR AS A CONSEQUENCE OF): resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO taideller 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO 26, PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL:
1 | inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 TES 2 100 me 5 Residence 8 Other (Specify) 27. MANNED OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 28b. TIME OF 1 Neturel 1 YES 2 NO BY 2 Accident 26s. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could n COMPLETED 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the causa(e) end manner as stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(e) end manner as stated. 296. SIGNATURE AND TITLE OF SERTIFIED 29d. DATE SIGNED (Mgnth, Day, Year) 29c. LICENSE NUMBER 8 3/1/

the Houn



	DR ATTEND	DIRECTOR: A	hours after d	Item 28 is
(THE HOSP	AH DE HE	file wells 7	HADRIANI

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	MENT OF HE	ALTH AND M	IENTAL HYGIEN		00510
	1. DECEDENT'S NAME (First, Middle, Lest) DOROTHY	M. Tay	Mildred	TAYL		2. DATE OF DEATH DATE OF THE D	AY YEA	
	4. SOCIAL SECURITY NUMBER 150~03-7726	1 M 2 XF 8			IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) June 26,1	8. B	IRTHPLACE (State or Foreign punity) Iew Jersey
TOR	9a. FACILITY NAME (If not institution, give st Clearview Nursin		98		LOCATION OF DEA		9c. COUNTY C	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Wash	nington		own or Location				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	100. STREET AND NUMBER 300 W. Northern				1P CODE 21740			OF WHAT COUNTRY?
В	11. MARITAL STATUS 1 X Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 XNO	If yea, specif	DENT OF HISPANIC	C ORIGIN? (Specify Yes Puarto Rican, alc.)	or No — 14. R	ACE — American Indian, lleck, White, atc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +)	life. Do NOT usa re	done during most c	of working	16b. KIND OF BUS	siness/industr	Y
BE CON	17. FATHER'S NAME (First, Middle, Last) William H. Taylo	or		.10		E (First, Middle, Maiden	Surname)	
10	19a. INFORMANT'S NAME (Type/Print) Robert T. Miller					ute Number, City or Town		
	20a. METHOD OF DISPOSITION 1 M Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	rom Stata ceme	PLACE AND DATE OF D stery, cremetory or other lest Haven	plece)			CATION — City o	n, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICE	Menn	rech		ADDRESS OF FACILITY OF FACILIT	L HOME		n, Md. 21740
	23. PART I. Enter the diseases, or coshock, or heert fallure. L. IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	I.	ch line.	enter tha mode	of dying, auch	aa cardiac or respi	ratory arrest,	Approximate Intervel Between Onset and Daeth
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa resulting in death) LAST	, P	CONSEQUENCE OF	Prter neis p	hene Hear	seal Strates & Disease	2— Q	
AL CE	PART II. Other aignificent conditions	contributing to death by	anot resulting in the		ause givan in Pa	ert I. 24a. WAS AN / PERFORI	AUTOPSY MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DE CAUSE
IN: MEDIC						1 YES 2	NO	DF DEATH? 1 YES 2 NO
IYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL:	tient 3 □ DOA 4 €	Nursing Home 5	OF DEATH (Check	Other (Specify)		
1 Netural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation 2 No 1 YES 2 NO 200. DESCRIBE HOW INJURY OCCURED								
COMPLEIED	4 Homicide detarmined	building, atc. (Specif	γ)			City or Town, State)		at Houte Number,
	(Check only one) 2 MEDICAL EXAMINER	IAN: To the best of my knowle On the basis of examination	end/or investigation, in	my opinion, death	occured at the tim	ne, date end place, end	dua to the cave	
崩	MIII			29	c. LICENSE NUMBE	EH	29d. DATE SIGN	ED Afronth Day March
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, Print) RANCES CE	()			▶ 3	110/93



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4. SOCI 2 : HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be made within 72 hours after death with the State Dept. of Health and Mental Hyglers prior to burial, cremation, or removal.

MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumetic event, the medical examiner must be notified at once. RESID TO BE COMPLETED BY FUNERAL DIRECTOR 10a. STA M 10e. STF 11, MARI BALTIMORE, MARYLAND 21215-0020 1 New Elem 17. FATH 19a. INFO Mrs
20a. MET
1 XI Bur
4 □ Dor 21. SIGN. 23. PAF iMMEDi disease resultin DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION Sequentificany, I cause. CAUSE that initiresulting PART II 25. WAS EXAJ 27. MANN
1 2 | 4 | 1 29a, CERTI. (Checkong)

MAR 1 9 03

Lulia Savidson-Randall

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FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTMI CERTIFICA			MENTAL	HYGIENE REG. NO.) (
1. DECEDENT'S NAME (First, Middle	a, Last)				2. DATE C	OF DEATH		3, TIME OF DEATH
Charle	< modfa	PN TRU	mbl.	50	MONTH	ch 14	199	EAR 10:00 M
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	In yrs. last birthday) IF U	NDER 1 YEAR	IF UNDER 24 HRS.		F BIRTH		BIRTHPLACE (State or Foreign
216 05 3910	1 🔀 M 2 🗌 F	94 YRS, MONT	THE DAYS	HOURS MIN.	(Month, 08-(Day, Year) 04-1898	3	(Country) MD
9a. FACILITY NAME (If not institution Har Fari) RESIDENCE OF DECEDE	Memorial H	ospital H	AVRE	DE GR	ATH ACE	=	Ha.	
	COUNTY	10c. CITY, TOY	WN OR LOCAT	ION				10d, INSIDE CITY
MD 10e, STREET AND NUMBER	Harford			lavre de	Gra	ce		LIMITS?
611 Lewis	Street		101.	210 210	78		10g. CITIZEN	USA
11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	VU.S. ARMED	13. WAS DEC	ENDENT OF HISPANI city Cuban, Mexican	C ORIGIN?	(Specify Yes o	r No- 14.	RACE American Indian, Black, White, etc.
1 Never Married 2 X Merrie 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D			2 NO Specify:		can, etc.)		Specify:
15. DECEDENT	'S EDUCATION	16a. DECEDENT'S USUA	I OCCUPATIO	M	405			White
(Specify only higher	st grade completed) College (1-4 or 5 +)	(Give kind of work d life. Do NOT use retin	one during mos		160.	KIND OF BUSH	vess/INDUS	THY
8	Conege (I-4 or 5+)	Diesel E	Engine	er	F	ederal	Gove	rnment
17. FATHER'S NAME (First, Middle, L	est)			18. MOTHER'S NAM		_		
Charles	Henry Trimble			Annie	e (Carr		
19a. INFORMANT'S NAME (Type/Prin			RESS (Street e	nd Number or Rural A			State, Zip Co	ode)
Mrs. Anna P.	Trimble	611 Lev	wis St	reet, Ha	vre (de Gra	ce, N	AD 21078
20a. METHOD OF DISPOSITION 1 N Burlal 2 □ Cremation 3 [PLACE AND DATE OF DIS			DATE	20c. LOC/	TION — City	or Town, State
4 Donation 5 Other (Specif	y)H	etery, cremetory or other plant arford Mem	orial	Gardens	3/18	Abe	rdeen	, Maryland
21. SIGNATURE OF FUNERAL SERV	S. S.		Mitch	ell-Smith e de Gra	Fur		lome, 21078-	
shock, or heart for iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	· Bytonio	ACONSEQUENCE OF):	77/10 tol	wording	11 105 c	myoci	esdie U	Approximate interval Between Onset and Death Size it 16 8 Face to the state of the state
1	nditions contributing to death b	ut not resulting in the	a underlying	cause given in F		24a. WAS AN AI PERFORM 1 - YES 2	ED?/	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDI	ICAL		26. PL	ACE OF DEATH (Che	ck only one)		
EXAMINER?	HOSPITAL: 1 (2 Inpatient 2 ER/Outp		HER:	5 🗆 Residence 8				
27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME OF	28c. INJI	JRY AT		RIBE HOW INJ	URY OCCUR	DED
1 Netural 5 Pendin 2 Accident Investig		INJURY	M 1 N	ES 2 ND				
3 Suicide 6 Could daterm	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, street,	factory, office		28f. LOCA City of	TION (Street en Town, State)	d Number or i	Rural Route Number,
29a. CERTIFIER 1 CERTIFYING	PHYSICIAN: To the heat of	lades decth	h- al-					
	PHYSICIAN: To the best of my know XAMINER: On the basic of examination							sussels) and messes as stated
			y opinion, or	THE PERSON NAMED OF THE PERSON NAMED OF THE PERSON NAMED OF THE PERSON NAMED OF THE PERSON NAMED OF THE PERSON NAMED OF THE PERSON NAMED OF THE PERSON NAMED OF THE PERSON NAMED OF THE PERSON NAMED OF THE PERSON NAMED OF T	mie, date a	nto prace, end	aus to the c	ausetal and manner ee stated.
Oug S	ON WHO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print)		29c, LIGENSE NUMI	BER		►MOZ	IGNED (Month, Day, Year)
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	308.	5.1	Inion	Ave	. Ho	Wre.	de Grace
MAD 7 9 to		AI UNE		14.	1)	2/09	1	

BALTIMORE, MARYLAND 21215-0020	e law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	ADDITION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	B-THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within a	are Fife function. After this certificate has been signed by the attending physician and completely filled in by the filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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DIRECTOR

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PHYSICIAN: MEDICAL CERTIFICATION

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6 Could not be determined

93 08980 **FOR** STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH P 1 AULOR 1840 Herbert 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign HOURS 1 N 2 F 69 YRS. 227/20/4125 1/14/1924 Maryland | Sa. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO RESIDENCE OF DECEDENT 16e, CITY, TOWN OR LOCATION 10d. INSIDE CITY Virginia Accomack Horntown 1 YES 2 X NO 10s. STREET AND NUMBER 10f, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 305012 Horntown Road, PO BOX 216 23395 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 17 TYPES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 NO Specify: Specify: 3 Widowed 4 Divorced white 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 11 Postmaster 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First Microla Maidan Sumama) Rosser A. Taylor Blanche M. Littleton 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann W. Taylor 305012 Horntown Rd., Horntown, Va. 20a. METHOD OF DISPOSITION

VX Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 4 Donation 5 Other (Specify) Downing's Cemetery 3
22. NAME AND ADDRESS OF FACILITY 13/7 Oak Hall, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Melson Funeral Home Milson PO BOX 64, Pocomoke City, Maryland 21851 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, **Approximate** shock, or heart failure. List only one cause on each line. interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition Cordine + Milmony arest resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate sturel atolomenel cause. Enter UNDERLYING CAUSE (Disease or injury aute averyson DOE TO (OR AS A CONSEQUENCE OF): that initiated events 24b. WERE AUTOPSY FINDINGS

Totaling in dealing Enter	d. Certeur,	schenolie (vosevlu dese
PART II. Other aignificant cor	nditions contributing to deal	th but not resulting in the	underlying cause given in Part

	24a. WAS AN AUTOPSY PERFORMED?
ı	1 TES 2 NO

AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO

25. WAS CASE REFI EXAMINER? 1 YES 2	PRAED TO MEDICAL	26. PLACE OF DEATH (Check only one) HOSPLFAL: 1 In Impelient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)				
27. MANNER OF DE 1 Accident	ATH 5 Pending Investigation	28e. DATE OF INJURY (Month, Day; Year)	20b. TIME INJU		28c. INJURY AT WORK? 1 YES 2 NO	28d. DEȘCRIBE HOW INJURY OCCURED
3 Suicide	building etc. (Specify)		ome, farm, street, factory, office		ctory, office	261. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a CERTIFIER	A STATE OF A STATE OF THE STATE	
(Check only	DENTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner as state	od.
onel		-

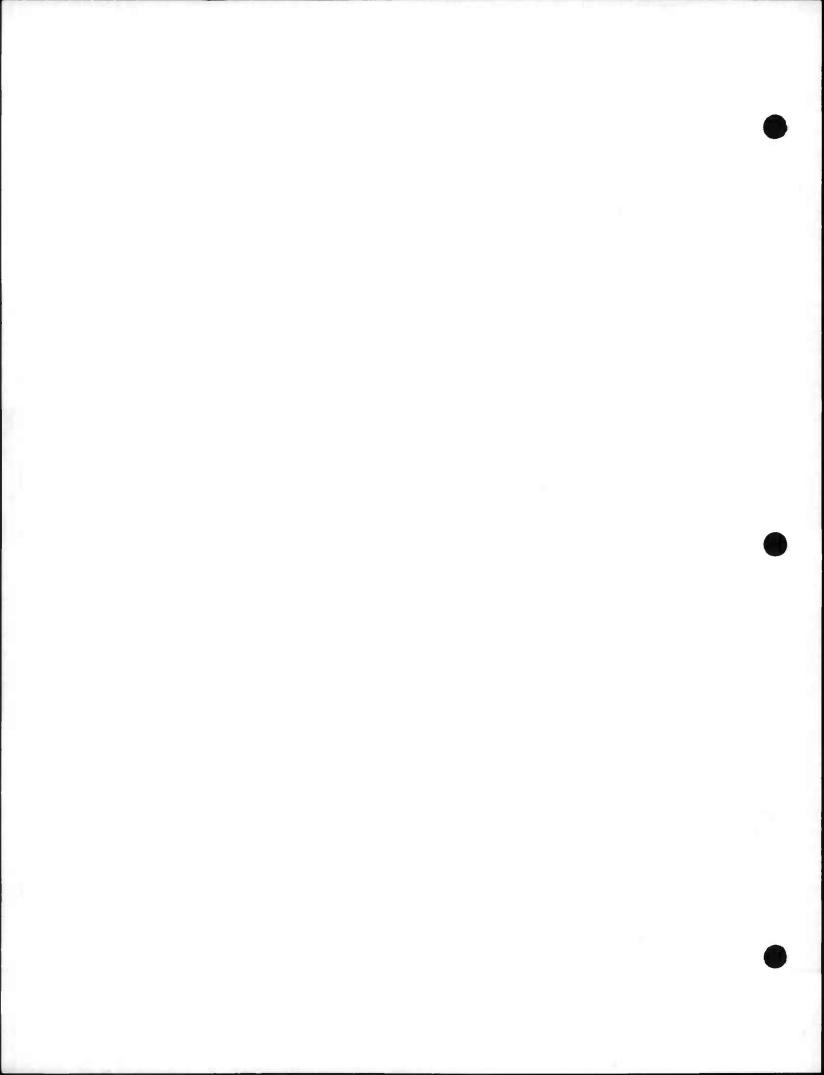
2 MEDICAL EXAMINER: On the basis of examination end/or investigation,	, in my opinion, death occured at the time, dete and place, o	and due to the ceuse(e) end menner ee stated.
295. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

(Mus A July & hus	D08211	1 3/4/92
O. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Non Print)		

-NSICY TR MED
32. REGISTRAR'S SIGNATURE 145 CALROLL STRUT SALISBURY MD

Lis Dendem Rendella

	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEI	PARTMEN	T OF H	EALTH AND I	MENTAL	HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Lest)						2. DATE C	OF DEATH			3. TIME OF DI	ATH
- 3		Harry Ho	lmes Vo	igt			Marc	h 14,		YEAR	10:00	Рм
		11	E (In yrs. last birth		R 1 YEAR	IF UNDER 24 HRS.	7. DATE O	F BIRTH Day, Year)	la	BIRTHP Country)	LACE (State or	Foreign
- 7	391-20-7001	1XXM 2 F	61 YF	NONTHS	DAYS	HOURS MIN.		6, 19	31		ucky	
	9a. FACILITY NAME (If not Institution, give street			9b. CIT		R LOCATION OF D	EATH		9c. COUNT	Y OF DE	ATH	
5	7500 Summit Avenu	ie			Che	y Chase			Mor	itgoi	mery	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c	CITY, TOWN	OR LOCAT	TON				T	10d. INSIDE C	TY
8	Maryland Mc	ontgomery		Chevy Chase						1XXYES 2 NO		
	10e. STREET AND NUMBER				10f. ZIP CODE 10g. CITIZEN O							
FUNERAL	7500 Summit Avenue	9			20815 Unit							25
5		12. WAS DECEDENT EVER		13.		ENDENT OF HISPAI				. RACE	- American In White, etc.	
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR	F YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Spe						Specify:			
	15. DECEDENT'S EDUCA	1957-1960	te- proppe	1				<u> </u>		Whit	е	
	(Specify only highest grade co	(Give kin	NT'S USUAL (d of work done OT use retired,)	durina ma		16b.	KIND OF BU	SINESS/INOUS	STRY			
2	Elementary/Secondary (0-12)	College (1-4 or 5+)	7++-					1				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	. 37	I ALLC	rnev		18. MOTHER'S NA		egal iddle, Maiden	Surname)			
BE C	Elmer William Voi	at.				Eleano	r Holi	mec				
	19a. INFORMANT'S NAME (Type/Print)	111.11	196. MAJ	LING ADDRES	S (Street a	nd Number or Rural			n, State, Zip C	ode)		
임	Marilyn Voigt		7500	Summ	it A	zenue, Ci	hevv	Chase	. Marv	land	d 208	15
	20a. METHOD OF DISPOSITION 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Remove											
	4 Donation 5 Other (Specify)			ery C	remai	orium.	Inc.	Bet	nesda.	Mai	ryland	
- 1	21. SKUNATURE OF FUNEFIAL SERVICE LICENSEE M00846 M00846 M00846 M00846 22. MAME AND ADDRESS OF FACILITY ROBERT A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501											
	Bethesda, Maryland 20814-3501											
	23. PART & Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
	IMMEDIATE CAUSE (Final											nd Death
	disease or condition resulting in death)	Cardiores	tory Arrest							Minu	tes	
			DUE TO (OR AS A CONSEQUENCE OF): tastatic Prostate Carcinoma							9 Ye	are	
S O	Sequentially list conditions, D. OUE TO (OR AS A CONSCOURNCE OF).											
¥	if any, leading to immediate cause. Enter UNDERLYING										j	
Ĕ	that initiated events	DUE TO (OR A	S A CONSEQUENC	CE OF):								
CERTIFICATION	resulting in death) LAST											
	PART II. Other significent conditions	contributing to deet	but not result	ing in the u	nderivin	r cause alven in	Part I	24a, WAS AN	Alimoney	1 245 1	WERE AUTOPS	CEMPINOS
PHYSICIAN: MEDICAL		, to doo.		ang in the G	nacriyii.	y cause given in	100	PERFOR	IMED?	7	MAILABLE PRICOMPLETION C	OR TO
					_		-	1 YES 2	Ж Уучо		OF DEATH?	
Σ.							_			`	1 TES 2	NO
AN	25. WAS CASE REFERRED TO MEDICAL				26. PI	ACE OF DEATH (Ch	eck only one)				
Sic		HOSPITAL:	utpatient 3 🗆 Do	OTHE		e 5 M Residence	6 Other	(Specify)				
	27. MANNER OF DEATH	28a. DATE OF INJUR (Month, Day, Year		TIME OF	28c. INJ				NJURY OCCU	RED		
ВУ	1 Netural 5 Pending 2 Accident Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		м	_	rES 2 NO						
	3 Suicide 6 Could not be	28e. PLACE OF INJU building, etc. (S	RY — Al home, fa	erm, street, fac	ctory, offic			TION (Street a	and Number or	Rural Ro	ute Number,	
	4 Homicide determined											
COMPLETED	(Check only CERTIFYING PHYSICIA	_										
Š	2 MEDICAL EXAMINER:	On the besis of examina	tion and/or investi	Igation, In my	opinion, d	eath occured at the	Ilma, date a	and place, an	d due to the	cause(a)	and manner a	stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIER	MBER		29d. DATE	SIGNED (Month, Day, Yo	ar)					
10 B	Saulius /1	aujen				D27398			Mar	ch 1	5, 199	93
-	30. NAME AND ADDRESS OF PERSON WHO											
	Saulius Naujokait			w Mexi	co A	ve.,N.W.	Wash	ingto	n, DC	20	016	
	31. DATE FILED (Month, Day, Year) MAR 16 '93	Julia David		-								
	145 TO 32	Juna way	Sont Hand									



E EMPERAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

The law requires that been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be betached for use as the burial-transit permit. Pages 1, 2, 3 should be betached for use as the burial-transit permit. Pages 1, 2, 3 should be betached for use as the burial-transit permit. BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL OR ALTHONIS LEWIS LAND. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the detached TO THE RUNERAL DIRECTOR. The majorities has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached filled within 72 hours. The majorities of the leath and Mental Hygiene prior to burial, cremation, or removal.

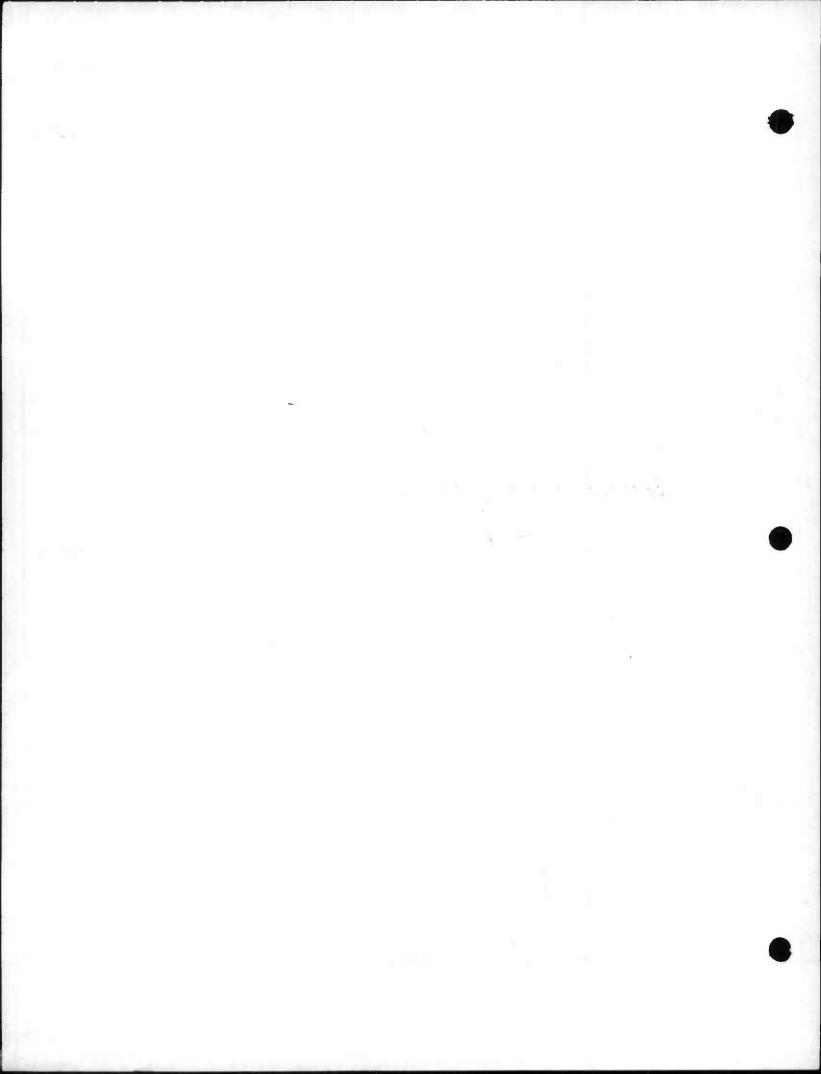
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

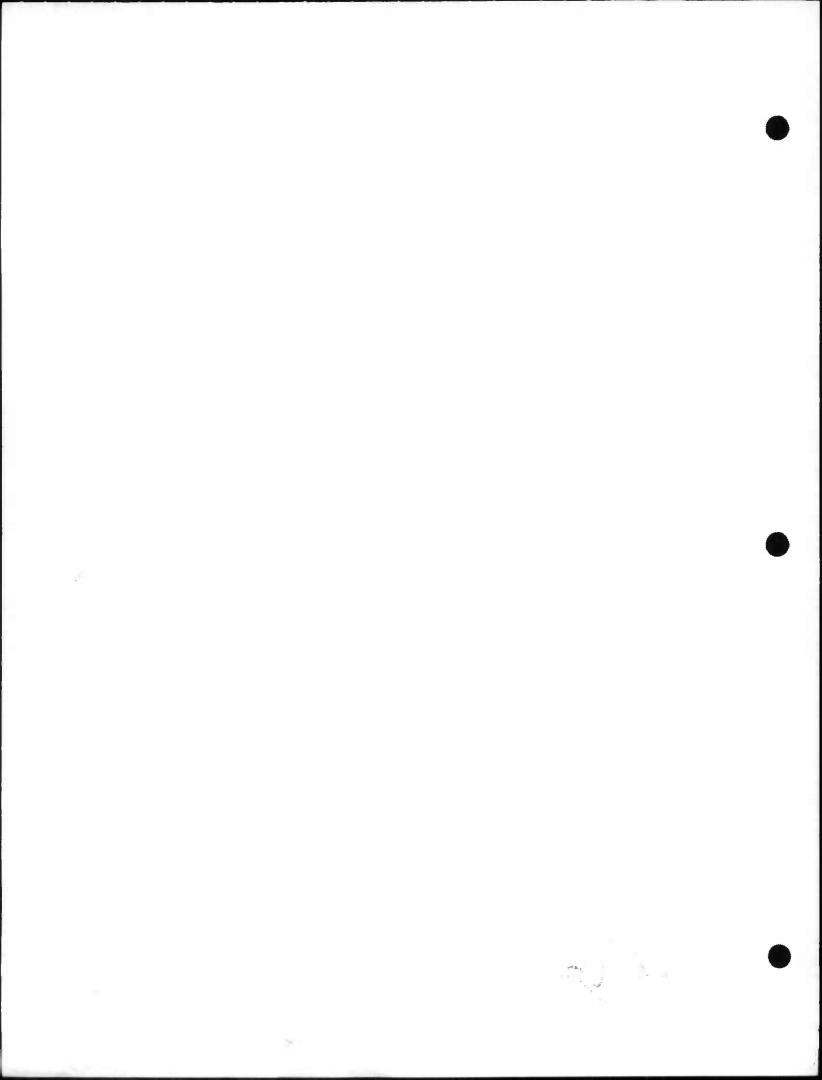
	REGISTRAR			CE	RTIF	ICATE O	F DEA	TH		REG. NO).			
	1. DECEDENT'S NAME (First, Mic	ddle, Last)						2. DATE O	F DEATH	MY		3. TIME OF DEA	ATH	
	CESAR MELO	QUIADES VI	ELASCO						MARCH		1993	YEAR	10:02	P
	4. SOCIAL SECURITY NUMBER 579-58-6454	1 🖹 M :	! 🗆 F	GE (In yrs. lest	birthday) YRS.	IF UNDER 1 YEAR		R 24 HRS. MIN.	7. DATE OF	BIRTH Day, Year)		BIRTHPLACE (State or Foreign Country) PERU		
10R	NIH, THE CI	LINICAL C				96. CITY, TOW BETHES		ION OF D			9c. COUNTY OF DEATH MONTGOMERY			
DIRECTOR	10a. STATE 10	b. COUNTY	7		10c. CITY, TOWN OR LOCATION					10d. INSIDE CI LIMITS?				
	10e. STREET AND NUMBER	ION I GOMEK.	L .		ROCKVILLE									NO
FUNERAL	8 VASHI LAN				20852							USA	WHAT COUNTRY?	
BY FU	1 Never Married 2 Married FORCES? 1 Forces 1 Forces 1 NOT AVAIL			R DATES	S 2 NO if yes, specify Cuben, Mexica DATES 1 YES 2 NO Specify					en, etc.)		14. RAC Blac Spec		
	15. DECEDE	AVAIL		16a. DECEDENT'S USUAL OCCUPATION					JVIAN			WHITH	Ξ	
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1.2			(Giv	(Give kind of work done during most of working life. Do NOT use retired.)						IMPRO		NTS	
S	17. FATHER'S NAME (First, Middle			16. MOTHER'S NAME (First, Midd							7 2012	THE D		
BE	CESAR VELAS	106	MAR INC	ADDRESS (Street	at and Number		AVIA		NCHEZ					
임	SHIRLEY RHOADS VELASCO										2			
	20s. METHOD OF DISPOSITION					ASHI LANE, ROCKVILLE, MARYLAND 20852 DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Sta								
3	1 Devile 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GATE OF HEAVEN CEMETERY 3/17/93										-		** ***	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00831 ROBERT A.S. PUMPHREY FUNERAL HOME/ ROCKVILLE, INC. 300 WEST MONTGOMERY AVENUE, ROCKVILLE, MARYLAND 20850-2805													
	23. PART I. Enter the disea	ises, or complicati	one that cau	used the des	th. Do i									
	immediate cause (Final disease or condition	t failure. Liet only	one ceuse o	n each line.			noue or dy	my, auc	or all ceruie	ic or resp	matory ar	rout,	Approxim Interval E Onset an	Between nd Daath
Н	disease or condition resulting in death) a										18 YE	ARS		
z	0.000 01 - 0.1													
읦	Sequentially list conditions if any, leading to immediat	e	DUE TO (OR A	AS A CONSECU	JENCE O	F):	1							
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	c												
ËI	that initiated events resulting in death) LAST		DUE TO (OR A	AS A CONSECU	JENCE O	F):								
ij I	• 10000	d												
DICAL	PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN A PERFORM									RMED?	MED? AVAILABLE PRIOR TO COMPLETION OF CAS		OT F	
W									_				OF DEATH?	NO
M	25. WAS CASE REFERRED TO ME	EOICAL				28.	PLACE OF O	EATH (C)	neck only one)					
Sic	EXAMINER?	HOSPI*	FAL:	Outpatient 3 (DOA	OTHER: 4 Nursing H				0				
PHYSICIAN:	27. MANNER OF DEATH	28a.	DATE OF INJU	RY	28b. TIM	E OF 28c.	NJURY AT	ISIDENCE	28d. DESCI	-	INJURY OC	CURED		
ВУР	1 Natural 5 Pend 2 Accident Inves	ding stigation	Month, Day, Ye	ar)	INI		YES 2	NO	-					
	3 Suicide 6 Cou	ld not be rmined	URY — At hom Specify)	ie, term, :	street, factory, of	fica		261. LOCAT	ION (Street l Yown, State)	and Number	or Rural i	Route Number,		
COMPLETED		NO PHYSICIAN: To the											a) and manner as	stated.
8	29b. SIGNATURE AND TITLE OF		2	MS	29c. LICENSE NUI								(Month, Day, Year)	
٩	of orall (rem 21) (type, run)									1/1)				
	31. DATF SLED (Month Pay, Year)	1 127	EGISTRAR'S S		OU R	OCKVILL	E PIK	Е, В	ETHES	DA, M	IARYL	AND	20892	
	MAR 16 %	1	O. M											

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	ATTENDING	-
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	HOSPITAL	
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	FOR 1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPAR	MENT OF HE	EALTH AND	MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
	DD TAMBENCE HADE	TENT TOANT MEET	n			MONTH D		YEAR CL. 22				
		SEN VAN MET		- Mariana		MARCH 14 1993 4:33						
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	BIRTHPLACE (State or Foreign Country)					
	351-18-5882	1 M 2 D F	71 YRS.		THE STATE OF THE S	JAN.11,19	LLINOIS					
	9a. FACILITY NAME (If not institution, give stre	net and number)		9b. CITY, TOWN OF	LOCATION OF D		-	Y OF DEATH				
H	MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY											
K	RESIDENCE OF DECEDENT											
DIRECTOR	10a. STATE 10b. COUNTY	10d, INSIDE CITY										
5	MARYLAND MONT	GOMERY	PO	CKVILLE				LIMITS?				
	10a. STREET AND NUMBER	GOMERI	KU		ZIP CODE		1	1 YES 2 NO				
A I	CONTROL MANAGEM			101.	ZIP CODE	The street of William Country of						
FUNERAL	4801 CAMELOT STREE				20853			USA				
ᆵ		12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DECE	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No— If yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. RACE — American is Black, Whita, atc.							
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	DATES		2 X NO Specif			Specify:				
	3 Widowed 4 Divorced	WW II					l W	HITE				
ETED	15. DECEDENT'S EDUCA (Specify only highest grade of		16a. DECEDENT'S	ISUAL OCCUPATION	1	16b. KIND OF BU	SINESS/INDUS	STRY				
Fi		College (1-4 or 5+)	life. Do NOT use	ork done during most retired.)	or working							
립		5+	ECONOMIS	т		AGRICUL'	TIIRAT	ЛЕРТ				
COMPL	17. FATHER'S NAME (First, Middle, Last)		LOCKOTILD		40.440001001010			DELI.				
				- 1		ME (First, Middle, Maiden	_					
BE	PHIL T. VAN MEIR				LOUISE	DeBRO						
<u>P</u>	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street and	d Number or Rural	Route Number, City or Tow	n, State, Zip C	ode)				
- 1	BETTY L. VAN MEIR	(WIFE) 4801 C	AMELOT S	TREET 1	ROCKVILLE,	MARYLA	ND 20853				
	20a. METHOD OF DISPOSITION 1 ☐ Burial 2 💢 Cremation 3 ☐ Ramov		b. PLACE AND DATEO					ly or Town, State				
	1 ☐ Buriel 2 💢 Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)		metery, crematory or oth	ner place)				recus time.				
1	21. SIGNATURE OF PUNERAL SERVICE LICES	uses / 0.0	<u>METROPOLI</u>		ATORY ADDRESS OF FA	3/1/ ALE.	XANDRI	A, VIRGINIA				
- 1	.41///	14 1111				LLINS FUNE	סע דאם	ME TNC				
	Mark -6.6	/ware		1				· ·				
	23. PART/I. Enter the diseases, or co	mplications that cause	d the death. Do n	ot anter the mod	of dving suc	h as cardian or rose	SIL.S	PR.,MD.20901				
- 1	shock, or heart failure. Li	at only one cause on	each line.	A P	e or cynig, sec	in as caldiac of resp	natory arres	it, Approximata Interval Between				
- 1	IMMEDIATE CAUSE (Final Onset a											
		TA A	0 - 0	7	. (.			Onset and Death				
	disease or condition resulting in death)	Myoca	rdial	Inde	etion							
		My ocal	A CONSEQUENCE OF	Infar	tion							
z	resulting in death) a.	DUE TO (OR AS	A CONSEQUENCE OF	Infare	tion Dise	ne						
NOI	resulting in death) a. Sequentially list conditions,	Como	A CONSEQUENCE OF	Infar	Dise	ne						
ATION	resulting in death) a.	Como	an a	Infac	Dise	ne						
FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO FOR AS	and a constance of children	Infar	Dise nua	ne						
ITIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO FOR AS	an a	Infar erele	Dise nua	ne						
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO FOR AS	and a constance of children	Infar erele	Dise nua	ne						
ᄗ	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO JOH AS	A CONSEQUENCE OF	erele	Dise nua	ne		onset and Death mule Month				
ᄗ	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO JOH AS	A CONSEQUENCE OF	erele	Dise	Part I. 24a. WAS AN						
ᄗ	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO JOH AS	A CONSEQUENCE OF	erele	Dise	Part I. 24a. WAS AN PERFO	MED7	Onset and Death War State of Charles of Charles of Charles				
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	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	DUE TO (OR AS HY PER I DUE TO (OR AS Contributing to death i	a donsequence of A consequence of but not resulting in	of Burning Home	CE OF DEATH (Co	PERFORM 1 YES 2 molt only one) 6 Other (Specify)	MED7	Onset and Death WWW. Jean 24b. WERE AUTOPSY FINDINGS AMALAIME PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
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BE COMPLETED BY PHYSICIAN: MEDICAL CI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO (OR AS HOSPITAL: Inpetient 2 ER/Out 28s. DATE OF INJURY (Moren, Day New) 28s. PLACE OF INJURY (Moren, Day New) On the basis of axamination	petient 2 DOA 285. TIME petient 3 DOA 285. TIME petient 3 name at the state of th	THE Underlying 28. PLA OTHER: a Nursing Home OF 26c, BIJUS MY 1 YE Peet, factory, office d at the time, date at , in my opinion, dea	S 2 NO	PERFORM 1 YES 2 molt only one) 6 Other (Specify) 26d. DESCRIME HOW (City or Naver, State) to the cause(a) and mer time, data and place, an	NJURY OCCUR and Number or oner as stated, d due to tha c	Onset and Death Well Jack J				
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BALTIMORE, MARYLAND 21215-0020

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		1 - FOR STATE REGISTRAR	STATE OF MARYL		TIMENT OF H		NTAL HYGIENE REG. NO.				
)	8	1. DECEDENT'S NAME (First, Middle, Last) AMERU	NV	/ASS	16 H	2.	DATE OF DEATH MONTH DAY	STAR STAR OF DEATH M			
9	Į.	4. SOCIAL SECURITY NUMBER 212-90-0416	1 Dai 2 D F	(In yrs. last birthday) 32 YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. 7. HOURS MIN.	DATE OF BIRTH (Month, Day, Year) 1ay 19 1959	8. BIRTHPLACE (State or Foreign Country) Lran			
2, 3 should	OR	SUBURBA-U	took and number)	TL	96. CITY, TOWN	TOWN OR LOCATION OF DEATH STHESDA MENDON					
	DIRECTOR	10a. STATE 10b. COUNTY	NTOMESS	10c. CIT	Y, TOWN OR LOCAT	TION PRI	ek.	10d. INSIDE CITY LIMITS?			
sit permit.	FUNERAL I	10e. STREET AND NUMBER	Im GR	MIR	CIRC	I. ZIP CODE		1 VES 2 NO CITIZEN OF WHAT COUNTRY?			
physician. burial-transit permit. Pages 1,		11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 ZINO	If yes, sp	ENDENT OF HISPANIC (ecity Cuben, Mexican, Pi 24 NO Specify:	ORIGIN? (Specify Yee or No- uerto Rican, etc.)	Black, White, etc.			
as the	ED BY	3 Widowed 4 Divorced 15. DECEDENT'S EDUC	ATION	16a. DECEDENT'S	USUAL OCCUPATIO	ON	16b. KIND OF BUSINESS/	SpecifyIranian			
pital or atte	COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	Give kind of the Do NOT us	work done during mo se retired.) List	st of working	Computer				
by the hospital of the detached for at once.	WO	17. FATHER'S NAME (First, Middle, Lest)				10. MOTHER'S NAME	First, Middle, Meiden Surnami	n)			
	BE C	Amir Vassighi				Parvi	n Unknown				
be retained ge 5 should e notified	10	Stoube Smith		19b. MAILING	Caylor A	ond Number or Rural Route ve. Ft. Wa	Number, City or Town, State, shington, Me	Zip Code) d. 20744			
e 6 may be ector, page must be		20e. METHOD OF DISPOSITION M	val from State 20b	PLACE AND DATE		3-22 -		- City or Town, State			
is after death. Page 6 may be by the funeral director, page emoval.		21. SIGNATURE OF UNERAL SERVICE LICENSE. 22. NAME AND ADDRESS OF FACILITY Hines Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spri									
24 hours / filled in tion, or n		23. PART. Enter the diseases, or coshock, or heart failure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death)	omplications that caused list only one cause on an	tha deeth. Do rech line.	not entar the mo	da of dying, such as	cardiac or reepiratory	arrest, Approximate Interval Between Onset and Daath			
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eath certifical attending phy ital Hyglene p	CERTIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):									
requires that t een signed by of Health and shows any I	MEDICAL	PART II. Other eignificent conditions	contributing to death b	ut not raeuiting	in the undarlying	g ceuse given in Per	24a, WAS AN AUTOPS PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO			
V: The law cate has t State Dept Item 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Check of	only one)				
ician: ertifica the Sta	IXSI	1 YES 2 NO	1 Inpatient 2 ER/Outp			e 5 🗆 Residence 8 🗆					
	ВУ РНУ	1 Manural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	3 180	OOM 1 0	PIK?	LUMPS A	A SOCKET			
TTENDI TOR: A after d	ETED	3 Suitcide 8 Could not be detarmined	28e, PLACE OF INJURY building, etc. (Spec	- At home, farm, s	street, factory, office	281	LOCATION (Street and Num City or Town, State)	ber or Rural Apage Number,			
12 A Z =	COMPLE		IAN: To the best of my knowl					stated, the ceuse(e) end menner ee stated,			
OTH HISPITAL THE FUNERAL MPORTANT: II	w	29b. SIGNATURE AND THE OF CERTIFIER				29c. LICENSE NUMBER		ATE SIGNED (Month, Day, Year)			
E P X	10	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED ON SE DE RE	1/4/		20709	9 >	3-1293			

32. REGISTRAN'S SIGNATURE

FOR

N. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours efter death, Page 6 may be retained by the hos	URECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached		If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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0	5	Nours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	Ĕ

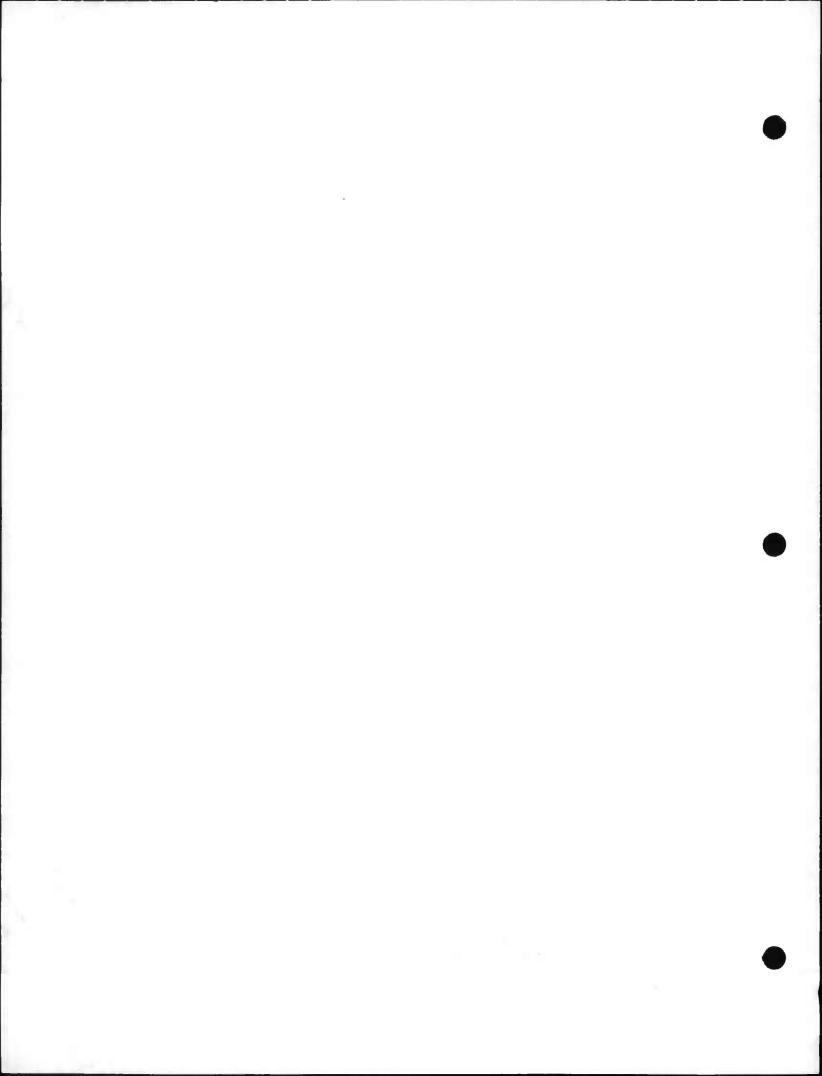
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICAE

_	1 - STATE REGISTRAR	CERTIF		OF DEATH	REG.	NO.				
	1. DECEDENT'S NAME (First, Middle, Lest) MARY R. VIAN	DS			2. DATE OF DEATH) ⁴	93	3. TIME OF DEATH 1430 PM		
ij	4. SOCIAL SECURITY NUMBER 5. SEX 6. A 1 1 M 2 XF	Alak	PLACE (State or Foreign Daster, MI							
DIMECTOR	9a. FACILITY NAME (If not institution, give attreet and number) Washington Adventist Hosp	oital		Takoma Park Sc. COUNTY OF DEATH Montgomery						
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR L	OCATION				10d. INSIDE CITY		
	Maryland Prince George	s Co	ollege	Park				1 X YES 2 NO		
FUNEHAL	9511 50th Avenue			20740	U.	U.S.A.				
à	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Dovorced 12. WAS DECEDENT EV. FORCES? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ES 2 XNO	ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 VES 2 NO Specify: Specify:					- American Indian, White, atc. White		
ELED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of a	e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)							
COMPLEI	12 17. FATHER'S NAME (First, Middle, Last)	Clerk		16. MOTHER'S NA	U.S.	Gove	rnme	nt		
BEC	Numan R. Roberts	Children Francisco State Contractor St								
2	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Tow							
	Robert O. Viands 20a. METHOD OF DISPOSITION		9511 50th Avenue, College Park, Maryland ACEAND DATE 20c. LOCATION - City or Town. Sta							
1	1 Buriel 2 X Cremation 3 Removal from State 4 Donation 5 Dther (Specify)	cemetery cremetory or o	tropolitan Crematory 3/11/93 Alexandria, Vi							
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	v	Fr	ancis Gasc B9 Baltimor	h's Sons					
	23. PART i. Enter the diseases, or complications that can shock, or heert failure. List only one cause of iMMEDIATE CAUSE (Final disease or condition resulting in death)	in each line.	ona	mode of dying, such		eapiratory a	rrest,	Approximate Interval Between Onset and Death		
AIION	DOE TO (OR	AS A CONSEQUENCE OF	F):	Failne						
CERTIFICA	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		CONSEQUENCE OF LEGGINICITIEN FRIENDS CHEST							
3	PART II ONLY IN THE STATE OF TH	700810						0812		
MEDICAL	PART II. Other algorificant conditions contributing to death but not resulting in the underlying couse given in Part i. OPCT: GGOGGERMAN DELLE COMPLETION OF CAUSE OF DELTON OF CAUSE OF CAUSE OF CAUSE OF CAUSE OF CAUSE OF CAUSE OF CAUSE OF CAUSE OF CAUSE OF CAUSE OF CAUSE OF CAU									
Y.	25. WAS CASE REFERRED TO MEDICAL	mas (5)	3161 Mic	sal Plusales	Justy.					
SICIAN: ME	EXAMINER? 1 VES 2 NO HOSPITAL: 1 Inpatient 2 ER/	Outpatient 3 DOA	OTHER:	6. PLACE DF DEATH (Che Home 5 - Residence						
	27. MANNER OF DEATH 1 Netural 5 Pending 28e. DATE OF INJU (Month, Dey, Ye	RY 28b. TIM	E OF 286	WORK?	28d. DESCRIBE HO	W INJURY O	CCURED			
200	2 Accident Investigation 3 Suicide 6 Could not be determined 28s. PLACE OF INJ building, etc. (URY — At home, farm, s Specify)			281. LOCATION (Str. City or Town, S	eet and Numbertate)	er or Rural Ro	oute Number,		
OMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my k one) 2 MEDICAL EXAMINER: On the beels of examine							and menner se stated.		
100	296. SIGNATURE AND TITLE OF CERTIFIER MONOMINA A. MOW	nan N	VD	29c. LICENSE NUM	IBER	29d. DA	TE SIGNED	(Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF MOHAM MED A MATT	DEATH (ITEM 27) (Type	Drinn)	3715 - R	HODE	156	44D1	AVE,		
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S S	BIGNATURE	/	MILAII	7126	((1)	10	112:		
	MAR 1 2 1993 Gulia D	avidson-Rande	elle							
	U							DHMH-16 Rev 1/89		

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g physician. g bvrial-transit permit. Pages 1, 2, 3 should	BY FUNERAL DIRECTOR	578-01-8748 9a. FACILITY NAME (If not institution, or Arcola Nursing RESIDENCE OF DECEDENTION, STATE 10b. CO Maryland Montion STREET AND NUMBER 4824 Flower Val 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced
d by the hospital or attending lid be detached for use as the data once.	BE COMPLETED I	15. DECEDENT'S (Specify only highest of the secondary (0-12) 11 17. FATHER'S NAME (First, Middle, Last Fitzhugh H
AN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician filtrate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trane. State Degr. or Health and Mental Hygiene prior to burial, cremation, or removal. If them 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	10 E	19e. INFORMANT'S NAME (Type/Print) Joan E. Lombard 20e. METHOD OF DISPOSITION 1 [X Burlet 2 Cremation 3 1 4 Donation 5 Other (Specify) 21. SIGNATURE OF BUILERAL SERVICE
ted within 24 hours after completely filled in by th al, cremation, or remove event, the medical		23. PART I. Enter the diseases, shock, or heart falls iMMEDIATE CAUSE (Fine) disease or condition resulting in death)
sath certificate be executated by sath certificate be executated by signification and tall Hygiene prior to burn to burn to burn traumatic	SERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
AN: The law requires that the death certificate be executed within 24 hours after fiscate has been signed by the attending physician and completely filled in by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal fillem 23 shows any Injury, or other traumatic event, the medical is	SICIAN: MEDICAL CERTIFICATION	PART II. Other significant conditions of the con
TTENDING PHYSICI TOP And the cert after death with the 28 is marked, o	PH	EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Netural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine
THE HARPITAL OR THE PLANTAL CHEE filed within 72 hours PORTANT: If Item	BE COMPLETED BY	294. CERTIFIER (Check only one) 2 MEDICAL EXAM 295. SIGNATURE AND TITLE OF CERT

	FOR STATE REGISTRAR		STATE OF I	MARYL	AND / DEPA CERTII					MENT	AL HYGIEN					
	1. DECEDENT'S NAME (First,	Middle, Last)								2. DAT	E OF DEATH	AY	YEAR	3. TIME OF DE	HTA	
1	Gertrude V.													9:20	AM	
	4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.					(Monin, Day, 16ar)			8. BIRTHPLACE (State or Foreign Country)		Foreign	
1	578-01-8748 Sa. FACILITY NAME (If not in:		1 M 2 F		76 YRS.						1, 19		1 32			
	Arcola Nurs	-	,					Spri		EATH	Montgomery					
	RESIDENCE OF DEC	EDENT							Ling			Inom	gome	EL y		
	10a. STATE	10b. COUNTY				TY, TOWN		ION						10d. INSIDE CI LIMITS?	TY	
	Maryland	Montgo	mery		Ro	ckvil								1 YES 2		
· water	4824 Flower	V2110	w Drive		101. ZIP CODE 20853									en of what country?		
	11. MARITAL STATUS	valle	12. WAS DECEDEN	T EVER IN	U.S. ARMED					NIC ORIG	IN? (Specify Ve		14 RACI	F American In	rition	
	1 Never Married 2	2 NO	If yes, specify Cuban, Mexics 1 YES 2 NO Specifi				can, Puerto Rican, etc.)				k, White, etc.					
	3 Widowed 4 Divor									7.				White		
İ	(Specify only	EDENT'S EDUC highest grade	CATION completed) College (1-4 or 5		(Give kind of life, Do NOT	IT'S USUAL OCCUPATION of work done during most of working				16	b. KIND OF BU	SINESS/INC	USTRY			
	Elementary/Secondary (0-	tor					Publis	hing	Comp	any						
	17. FATHER'S NAME (First, Min	oldle, Last)						18. MQTI	HER'S NA	ME (First,	Middle, Maiden	Surname)			_	
ı	Fitzhugh	Ноо	d						res			_	ers			
1	19a. INFORMANT'S NAME (Ty	rpe/Print)			19b. MAILIN	G ADDRES	S (Street a	nd Number	or Rural	Route Nu	nber, City or Tow	m, State, Zip	, Zip Code)			
i	Joan E. Lom				4824	F1owe	r Va	r Valley Dr., Rockville, MD 20853								
	20a. METHOD OF DISPOSITION 1 Burlai 2 Cremation	OF DISPOS	of Disposition (Name of oate of Disposition (Name of oate other place) In Cemetery 3/10/93 20c. LOCATION — City or Town, State Brentwood, Maryland							1						
	4 Donation 5 Other		succes)	Fo	rt Linc					10/9	3 1516	ILWOC	d, r	larylan	a	
Ì	11	C	1/.	340	0077			inco			ral Ho	me. T	nc.	3401		
4	1 Cerl	16.	time		0877	B1	ader	sbur	gR	d.,	Brentw	ood,	MD			
	23. PART I. Enter the disshock, or he iMMEDIATE CAUSE (Findisease or condition resulting in death)	eart failure.	List only one cau	ise on e	CONSEQUENCE			he,				-			Between and Death	
	Sequentially list condition if any, leading to immedicase. Enter UNDERLYII CAUSE (Disease or Injuint that initiated events resulting in death) LAST	fliste NG ry	t		CONSEQUENCE (
	PART II. Other significant			deeth be	ut not resulting	in the ur	derlying	ceuse ç	jiven in	Part i.	24a. WAS AN PERFOR 1 YES 2	RMED?	24b	WERE AUTOPSY AMAILABLE PRIC COMPLETION O OF DEATH?	R TO F CAUSE	
í	25. WAS CASE REFERRED TO	MEDICAL					26. PL	ACE OF D	EATH (Ch	eck only	ige)					
í	EXAMINER? 1 YES 2 NO		HOSPITAL:	ER/Outp	atient 3 DOA	OTHEI	₹:				er (Specify)					
	27. MANNER OF OEATH		28a. DATE OF (Month, D	INJURY	28b. Til	_	28c. INJ	JRY AT			SCRIBE HOW I	NJURY OC	CURED			
t		Pending nvestigation	(-,,,		М		E\$ 2 [NO							
1		Could not be letermined	28e. PLACE O building,	F INJURY etc. (Speci	— At home, farm,	street, fact	ory, office				CATION (Street or Town, State)		or Rural I	Route Number,		
			CIAN: To the best of R: On the bests of a											s) and manner as	stated.	
	29b. SIGNATURE AND TITLE	THE REAL PROPERTY.			-			29c. LICE						(Month, Day, Yes		
	Lane	. 8/						D	340	32				8, 199		
	Jeanne P. As	sher,					ue,	Kens	ing	ton,	MD 20	0895				
	MAR 1 0 199	3 g	32. REGISTRA	R'S SIGNA	ndell	3										



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HIGH DISCIAR: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the bospital or attending physician.

TO THE FUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be attended for use as the burial-transit permit. Pages 1, 2, 3 should be attended to use as the burial-transit permit. Pages 1, 2, 3 should be attended to use as the burial-transit permit. Pages 1, 2, 3 should be attended, or litem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLANI	D / DEPARTMENT CERTIFICATI			NTAL HYGIEN		0000
	1. DECEDENT'S NAME (First, Middle, Last)	// u A.	1.0000-0		2.	DATE OF DEATH		3. TIME OF DEATH
1 8	MAYETTE		JERSBER(5		03	3	
		5. SEX 6. AGE (In yrs	t. last birthday) IF UNDER	DAYS		DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	9s. FACILITY NAME (If not institution, give stre			/ TOWN OF	R LOCATION OF DEATH	2c. 29 18		New York
DIRECTOR	Anne Arundel Medic			nnap				Arundel
E E	10s. STATE 10b. COUNTY	1. 1.0	10c. CITY, TOWN		ON			10d. INSIDE CITY
		Arundel	Annapo	ilis				1 TES 2 NO
FUNERAL	10e. STREET AND NUMBER			101.	ZIP CODE		,	N OF WHAT COUNTRY?
N.	445 Delso Court	12. WAS DECEDENT EVER IN U.S.	ADMED	WAS DESC	21401			ted States
	1 Never Married 2 Married	FORCES? 1 YES 2	[X]1/0	If yes, spec	NDENT OF HISPANIC Of Colfy Cuben, Mexican, Pu	erto Rican, etc.)	or No- 14	S. RACE — American Indian, Black, Whits, atc.
BY	3√Widowed 4 □ Divorced			1 1 123	Specify.			Specify: White
COMPLETED	15. DECEDENT'S EOUCA (Specify only highest grade of	TION 16a.	DECEDENT'S USUAL O	CCUPATION during most	t of working	16b. KIND OF BU	SINESS/INDUS	TRY
1 2	Elementary/Secondary (0-12)	College (1-4 or 5+)	Homemaken	t.		Ho	no	
WO	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (/			
BE C	unknown				,	unknown	,	
5	19s. INFORMANT'S NAME (Type/Print)				d Number or Rural Route			ode)
-	Patricia Ferri		445 Delso	Cou	rt Annapo	olis, MD	21401	
	20s. METHOD OF DISPOSITION 1 Buriel (Cremation 3 Remov		CEAND DATE OF DISPOS , cremetory or other piece)		1			y or Town, State
	4 Donation 6 Other (Sophin)	ISE AT I	Lincoln Cr	Lemat	OTU 03-16-	-93 Br	<u>entwo o</u>	d. Maryland
	NAL V	ay lo	11	17 Du	ha al Clai	John M.	. layk	or Funeral Home napolis, MD
\vdash	23. PART I. Entry he diseases, or co	Applications that caused the						
	anock, or heart fellure. Li	st only one ceuse on each i	line.	the mod	e or aying, such es	ceralec or respi	ratory arres	Interval Between
	iMMEDIATE CAUSE (Finel disease or condition	BRI	AST CA	Ter	GR 141		1	Cill M D46
	resulting in death) a.	OUE TO (OR AS A CON	ISEQUENCE OF):	1100	3 10	(F1173)	m'C	OWNINGS
Sequentially list conditions, b. DUE TO OR AS A CONTROLLED								
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.								
FIG	CAUSE (Diseese or Injury c. thet initieted events	DUE TO (OR AS A CON	ISEOUENCE OF):					
EFIT	resulting in death) LAST							
AL C	PART II. Other significent conditions	contributing to deeth but no	ot resulting in the un	nderlying	ceuse given in Part	1, 24a, WAS AN	ALITOPSY	24b. WERE AUTOPSY FINDINGS
	CARDI	MYTAATYMO	tu			PERFOR	IMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC						1 123 2	X.	OF DEATH?
ž								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	ĮQSPITAL:	OTHER		CE OF OEATN (Check or	nly one)		
17S	1 YES NO 1	28s. DATE OF INJURY	t 3 DOA 4 Nun	sing Home	5 Residence 6 🗆			
	Natural 5 Pending	(Month, Day, Year)	28b. TIME OF INJURY M	28c. INJUI WOR		. OEŞCRIBE NOW II	NJURY OCCUR	REO
Э ВУ	2 Accident Investigation 3 Suicide 6 Could not be	26s. PLACE OF INJURY — AI	t home, farm, street, fact			LOCATION (Street a	and Number or	Rural Route Number,
	4 Homicide determined	building, stc. (Specify)				City or Town, State)		
MPLETED	29e. CERTIFIER (Check only	AN: To the best of my knowledge,	, death occurred at the t	ime, date s	nd place, and dus to th	e cause(s) and man	iner ss stated.	
CON		On the basis of examination and						euse(s) and manner as atated.
BE (296. SIGNATURE AND TITLE OF CERTIFIER		211		29c. LICENSE NUMBER	/ /	29d. DATE S	INEO (Month Day, Year)
10	30. NAME AND ADDRESS OF PERSON WHO	MOSE	_ MM)		1) 163	164	1 3	115195
	900 RESIS	ARE RO	10 A dos	A	Saffin	is wo	21	401
	31. DATE FILED MONTH, Day 1691	Juna Davidson-P	Andre					

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BALTIMORE, MARYLAND 21215-0020	SCAN. The two mounts that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Certificate has been upped by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.	i examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	THE HOSA TALL ON ATTENDING PHYSCRAN. The law inquires that me death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician . TONHE TUNERAL DIRECTOR. After this certificate has been upped by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be median. The certificate has been upped by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

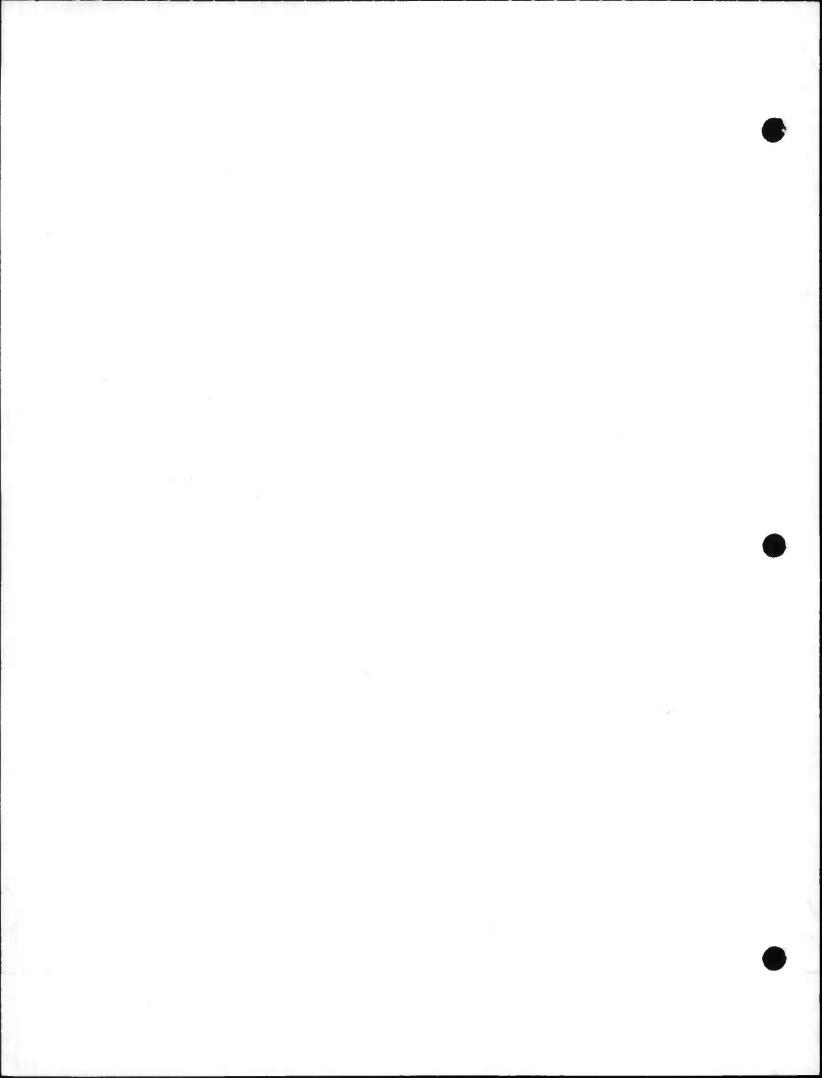
31. DATE FILED (Month, Day, Year)
MAR 16 93

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1 - FOR STATE REGISTRAR		STATE OF M	ARYLAND C	DEPAR	TMEN ICAT	T OF H E OF	EALTH DEAT	AND I		YGIEN EG. NO.	E		
1. DECEDENT'S NAME (First, A	fiddle, Lest)								2. DATE OF	DEATH DA		YEAR	3. TIME OF DEATH
MARY	JOHNSO	ON WILLI	AMS						MARCH	14		993	3:15PM M
4. SOCIAL SECURITY NUMBER	R 5	S. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDE		IF UNDER		7. DATE OF 1 (Month, De			8. BIRTH	IPLACE (State or Foreign
239-03-313	32 1	□ M ZXXXF	88	YRS.	MONTHS	DAYS	HOURS	MIN.	JAN.		1905		TH CAROLINA
9e. FACILITY NAME (If not insti	tution, give stree	et and number)			9b. CIT	Y, TOWN C	A LOCATIO	N OF DE				NTY OF D	
COLLINGSWOO	DD NURS	SING CEN	TER		RO	CKVI	LLE				MO	NTGO	MERY
COLLINGSWOO RESIDENCE OF DECE 100. STATE MARYLAND	DENT			_							_		
TOR. STATE					1,700	OR LOCAT							10d. INSIDE CITY LIMITS?
	CNOM	rgomery			GAIT	HERS							1 X YES 2 NO
10e. STREET AND NUMBER 13 BRIGHTON 11. MARITAL STATUS						101	ZIP CODE				10g. CIT	IZEN OF V	WHAT COUNTRY?
13 BRIGHTON	TERRAC	CE					208	377			UN	ITED	STATES
11. MARITAL STATUS		2. WAS DECEDENT FORCES? 1			13.	WAS DEC	ENDENT OF	F HISPAN	NIC ORIGIN? (S	pecify Yes	or No-	14. RACE	E — American Indian, k, White, etc.
1 Never Married 2 M 3 Widowed 4 Divorce		IF YES, GIVE W		,			2 X NO			1, 416-7		Spec	
													WHITE
(Specify only t	DENT'S EDUCAT highest grade co		(Give kind of the Do NOT u	work done	during mo	M st of working	g	16b. KIN	ID OF BUS	SINESS/INI	DUSTRY	
Elementary/Secondary (0-1)	2)	College (1-4 or 5+)											
15. DECEL (Specify only I Elementary/Secondary (0-1:		1	1	HOMEM	AKER						HOM:	E	
									ME (First, Midd				
CORNELIUS		ETCHER	JOH					ANNA		FRAN			MOORE
194. INFORMANT'S NAME (Typ									Route Number, (-			
ROGER M. WILLIAMS 13 BRIGHTON TERRACE, GAITHERSBURG, MA 20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of camelery, crematory or other place) 3/20/93 ROCKINGHA								_					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE MO0831 22. NAME AND ADDRESS OF EACHTY ROCKVILLE, INC. 300 WEST MONTGOMER ROCKVILLE, INC. 300 WEST MONTGOMER								INA					
						OME/							
							MERI 50-2805						
						ratory an	rest,	Approximate					
						Interval Between Onset and Death							
disease or condition													
resulting in death)	a		OR AS A CONS	EQUENCE O	F):								
	6 b.	CHRONIC URINARY TRACT INFECTION DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list condition if any, leading to immediate	ns,												
cause. Enter UNDERLYIN	OSCLERO	CLEROTIC CEREBRAL VASCULAR DISEASE											
CAUSE (Disease or injury that initiated events C. ARTERIOSCIEROTIC CEREBRAL VASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF):													
resulting in death) LAST d. ARTERIOSCLEROTIC CORONARY ARTERY DISEASE													
							WESE ATTOREY ENDINGS						
				· · · · · · · · · · · · · · · · · · ·			, couse y			PERFOR		240	AVAILABLE PRIOR TO COMPLETION OF CAUSE
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. WAS PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 29. PLACE OF DEATH (Check only one) 20. PLACE OF DEATH (Check only one) 20. PLACE OF DEATH (Check only one) 21. PLACE OF DEATH (Check only one) 22. PLACE OF DEATH (Check only one) 23. PLACE OF DEATH (Check only one) 24. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Inpution 2 ER/Outpetient 3 DOA 26. PLACE OF DEATH (Check only one) 27. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 29. PLACE OF DEATH (Check only one) 20. PLACE OF DEATH (Check only one) 20. PLACE OF DEATH (Check only one) 20. PLACE OF DEATH (Check only one) 21. PLACE OF DEATH (Check only one) 22. PLACE OF DEATH (Check only one) 23. PLACE OF DEATH (Check only one) 24. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Inpution 2 ER/Outpetient 3 DOA 26. PLACE OF DEATH (Check only one) 27. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 29. PLACE OF DEATH (Check only one) 20. PLACE OF DEATH (Check only one) 20. PLACE OF DEATH (Check only one)							OF DEATH?						
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25. WAS CASE REFERRED TO	MEDICAL T	28. PLACE OF DEATH (Check only one)											
EXAMINER?	F	IOSPITAL:			OTHE		ACE OF DE	EATH (Ch	eck only one)				
1 YES 2 NO	1	Inpatient 2			_			Idence	6 Other (Sp				
1 Natural 5 Pe	ndina	28e. DATE OF I (Month, De		28b. TIM	IE OF JURY	WO	JURY AT 28d. DESCRIBE HOW INJURY OCCUREO DRK?						
2 Accident Im	restigation	M 1 TYES 2 28e. PLACE OF INJURY — At home, farm, street, factory, office											
	ould not be termined	building, e	INJURY — At h	ome, farm,	street, fac	tory, office	1.		281. LOCATIO City or To	N (Street e wn, State)	nd Numbe	r or Rural F	Route Number,
		W: To the beat of r											
2 MEDICA	AL EXAMINER:	On the basis of exi	mination end/or	r Investigatio	on, In my	opinion, d	eath occure	d at the	time, date and	place, en	d due to t	he cause(e	e) end manner ee stated.
29b. SIGNATURE AND TITLE	CENTIFIER	/					29c. LICE	NSE NUR	MBER		29d. DAT	E SIGNED	(Month, Day, Year)
and the same mil				0		29d. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey. Yeer D36618 MARCH 15,1993				15,1993			

OR. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

CHRISTOPHER SCHEMM, M.D. 849-B QUINCE ORCHARD BLVD., GAITHERSBURG, MD. 20879

32. BEGISTRAR'S SIGNATURE
Julia Davidson Pandalle



burial-transit permit. Pages 1, 2, 3 should

DIRECTOR

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DEACHT WINDIETY 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION 20b. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION 20c. METHOD OF DISPOSITION 2
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20b. PLACE AND DATE OF DISPOSITION 1 To Burlet 2 Cremetion 3 Removal from Stand 4 Donation 5 Other (Specify) 21. SIGNATURE OF FINERAL SERVICE-LICENSEE 22. PART I. Enter the disease, or complications that caused the death. Do not enter shock, or heart fallibre. List only one cause on each line. 12. Signature of Fineral Service-Licensee 23. PART I. Enter the disease, or complications that caused the death. Do not enter shock, or heart fallibre. List only one cause on each line. 24. Donation 5 Other (Specify) 25. PART II. Enter the disease, or complications that caused the death. Do not enter shock, or heart fallibre. List only one cause on each line. 26. DUE TO (OR AS A CONSEQUENCE OF): 27. DUE TO (OR AS A CONSEQUENCE OF): 28. DUE TO (OR AS A CONSEQUENCE OF): 29. DUE TO (OR
23. PART I. Enter the diseases, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final diseases or condition) The summan and completely life in by the
23. PART I. Enter the diseases, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final diseases or condition) The summan and completely life in by the

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Julia Davidson

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH **EDNA** B. WINDHEIM 12:05 8 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or 1 M 2 F HOURS 082-10-2275 YRS. 12-21-14 78 POLAND 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND HOWARD 1 - YES 2 X NO COLUMBIA 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6108 STEVENS FOREST ROAD 21045 UNITED STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 TO NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerio Ricen, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried WHITE OCCUPATION ne during most of working 16b. KIND OF BUSINESS/INDUSTRY OWN HOME 18. MOTHER'S NAME (First, Middle, Meiden Sumerne) LENA BROCK ESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ENS FOREST ROAD, COLUMBIA, MD 21045 20c. LOCATION - City or Town, State DATE **CEMETERY** 3-12 CROWNSVILLE, MD 2. NAME AND ADDRESS OF FACILITY ANZANSKY-GOLDBERG MEMORIAL CHAPELS 170 ROCKVILLE PIKE, ROCKVILLE, MD ter the mode of dying, such as cardlec or respiretory arrest, Approximeta interval Between Onset and Death NIA 10 underlying ceuse given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE HLUPE 1 TES 2 100 OF DEATH? 1 | YES 2 | NO 28. PLACE OF DEATH (Check only one) ursing Home 5 - Residence 8 - Other (Specify) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO ctory, office 281. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) e time, date end place, end due to the cause(e) end menner ee stated. 2 __ MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Calivas, Ms 036552 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PANKAJ TALWAR ROCKVILLE MD. 20832 6121 MONTROSE 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

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res that the death certificate be executed within	igned by the attending physician and completely	ealth and Mental Hygiene prior to burial, crema	s any Injury, or other traumatic event
ITTENDING PHYSICIAN: The law requi	CTUR. After this certificate has been s	after death with the State Dept. of H	28 is marked or item 23 show
MONTH OF	FUNDAL DIFE	Jack 72 hours	TTANT: If Harm

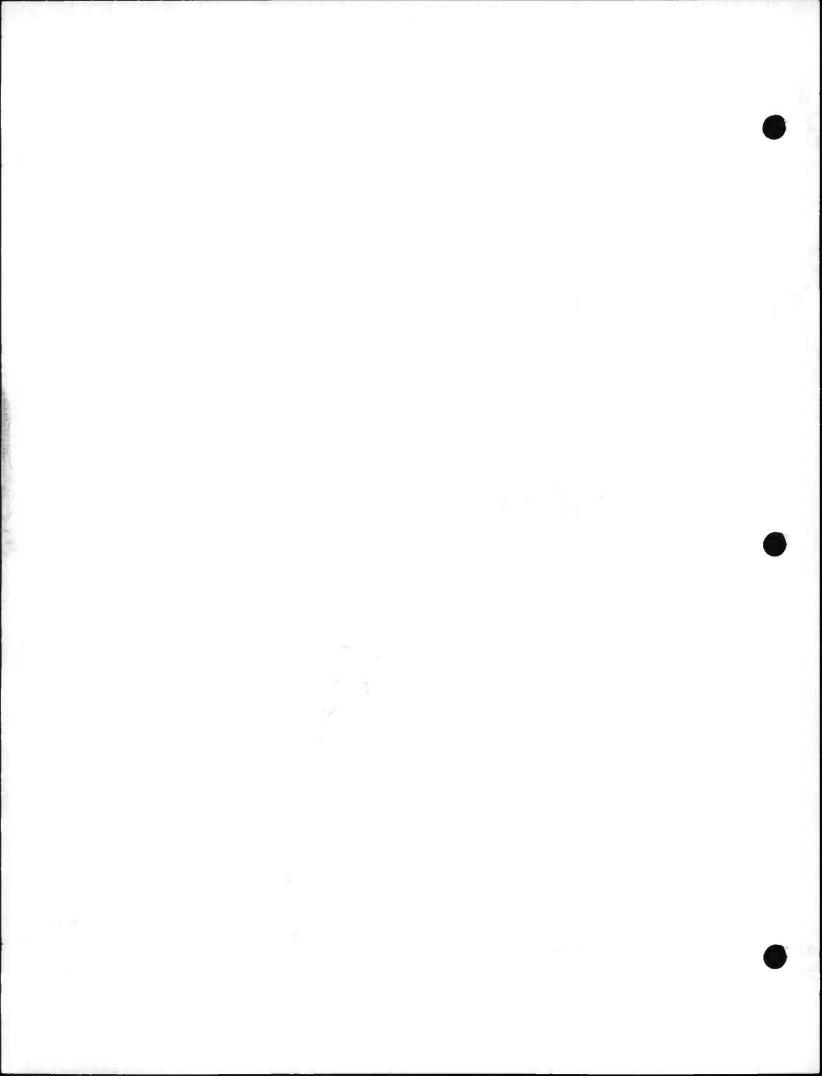
pnid

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH WORSLEY GERTRUBE CARR march 93 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign (Month, Day, Year) Feb. 28, 1908 219-36-7964 1 🗌 M 2 🔯 F West Virginia Sa. FACILITY NAME (If not institution, give street and number) 96, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATN DIRECTOR Washington Adventist Hospital Takoma Park Montgomery RESIDENCE OF DECEDENT 10s. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3322 Chiswick Court #2-F 20906 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea, specify Cuban, Mexican, Puerto Rican, etc.)
 \(\sum_{YES} \) YES 2\(\overline{\text{X}}\) NO Specify: RACE — American Indian, Black, White, etc. FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married В Specify: White 3XX Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) Coflege (1-4 or 5+) Montgomery County 4+ Teacher Public Schools 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jesse Carr Sally Eddy BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Pural Route Number, City or Town, State, Zip Code) 2 Fred Basgier 11918 Mid County Dr., Monrovia, Maryland 20s. METHOD OF DISPOSITION (
1 Disposition 5 Cremitton 2 Donation 5 County) 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of Geo Wash Univ Med Sch 3-6-93 Washington, D.C. Columbia Mortuary Services, Inc. 225 Missouri Avenue, NW Washington, DC 20011 acu Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart feilure. Liet only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition_ Coronary arlen 44 resulting in death) heroscheroric caro yes CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF)resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY my ocaro ias margin 1 YES 2 THO popertersin 1 YES 2 NO conegative heart talliere PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) HOSPITAL:
1 Dinpetient 2 ER/Outpetient 3 DOA OTHER: 1 | YES 2 | 16 4 I Num 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 ND BY 2 Accident 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 8 Could not be COMPLETED 4 Nomicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 2 $\ \square$ MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, de occured at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND THE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) 28791 3/6/93 9 ESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IJEM 27) (Type, Print) 10401 Old Georgetown Rd. Bethesda 20814 _eonard Koger

122. AKGISTAN S. SIGNAMAN

31. DATE FILED (Month, Day, Year)

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1. DECEDENT'S NAME (First, Middle, Last) VERNA C. WELLS 2. DATE OF DEATH 3. TIME OF DEATH wells عامد YEAR tis Ver Vo 4 SOCIAL SECURITY NUMBER 5 SEY 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH S. BIRTHPLACE (State or Foreign 1 M 2 F 577-18-6009 OCT. 2, 1917 WASHINGTON, D.C. as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 14639 BAUER DRIVE ROCKVILLE MONTGOMERY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY ROCKVILLE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 14639 BAUER DRIVE 20853 USA hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. If yes, apecify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Marrie 2 X NO Specify: BY 3 🔯 Widowed 4 🗌 Divorced WHITE COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION use (Specify only highest grade comp Ď Elementary/Secondary (0-12) College (1-4 or 5+) detached SECRETARY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at page 5 should be JAMES WESLEY CURTIS ADAH B. ANDERSON 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Pural Route Number, City or Town, State, Zip Code) 2 NEAL W. WELLS, (SON) 600 EASLEY STREET SILVER SPRING, MD 20910 pe 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State director, J must 4 Donation 5 Other (Specify) cemetery, crematory or other place)
FORT LINCOLN CEMETERY 3/16 BRENTWOOD, MARYLAND 5. Other (Specify) examiner 21. SIGNATURE OF F NERAL SERVICE LICENSEF 22. NAME AND ADDRESS OF FACILITY the funeral FRANCIS J. COLLINS FUNERAL HOME, INC. (0 500 UNIVERSITY BLVD., W. SIL.SPR., MD. 20901 removal. medical 23. PART I. Enter the diseases, or complic ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, filled in by Approximate shock, or heart fallure. List only one cause on each line. 6 IMMEDIATE CAUSE (Finei Onset and Death the attending physician and completely fille Mental Hygiene prior to burial. cremation, the Cardioconcelor Disease within 24 disease or condition_ event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if sny, leading to immediate cause. Enter UNDERLYING 2 death certificate CAUSE (Diseese or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 this certificate has been signed by the with the State Dept. of Health and Me PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS requires that the AMAILABLE PRIOR TO COMPLETION OF CAUSE any 1 YES 2 NO OF DEATH? Shows 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH-/Check only one! ltem. HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: YES 2 NO 5 Residence 8 - Other (Specify) 6 27. MANNER OF-DEATH 28e. DATE OF INJURY 28c, INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED is marked, Seatural 5 Pending Investigation 1 YES 2 NO DIRECTOR: After thours after death BY 2 Accident 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 28 4 Homicide tem OR 29a. CERTIFIER

(Chack note 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. (Chock only one)

CERTIFYING PHYSICIAN: 10 the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(e) and menner as stated.

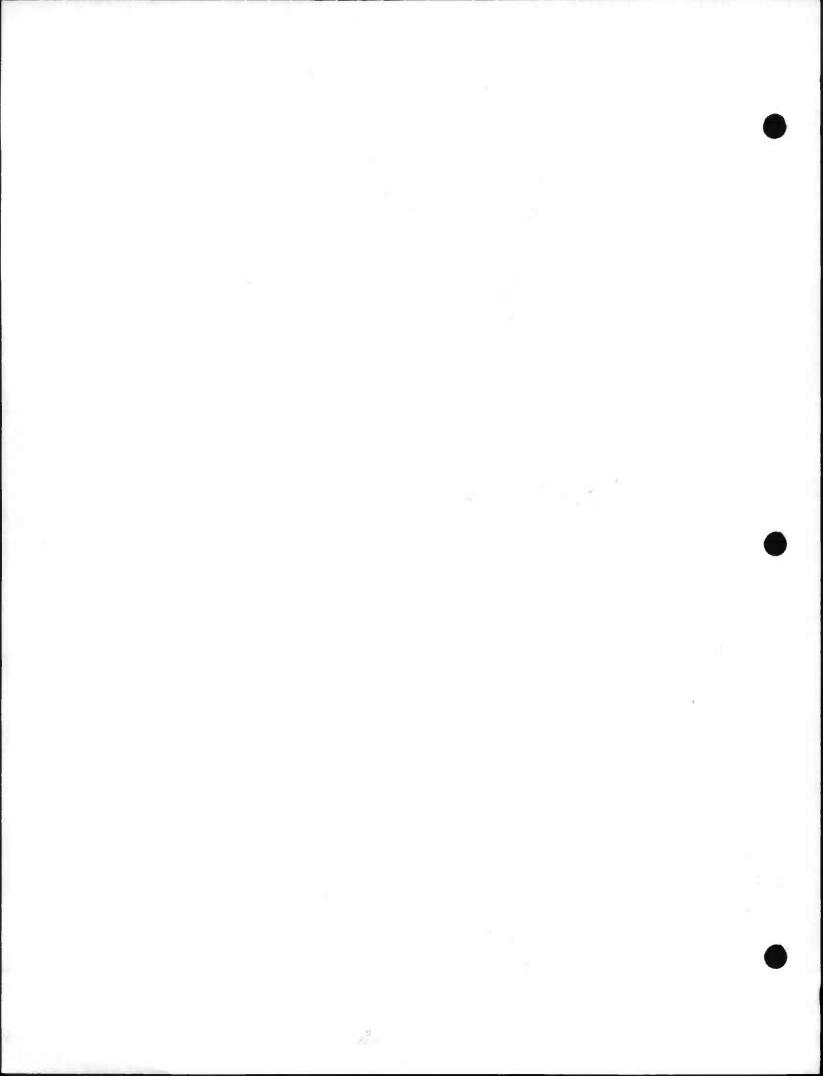
MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner as stated. 20 = 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE G R546 372-9 MS 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Codas Bul 5218 @ Sansins Des (20 31. DATE FILED (Month, 32. REGISTRAR'S SIGNATURE

whia Devidson Randoll

'93

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

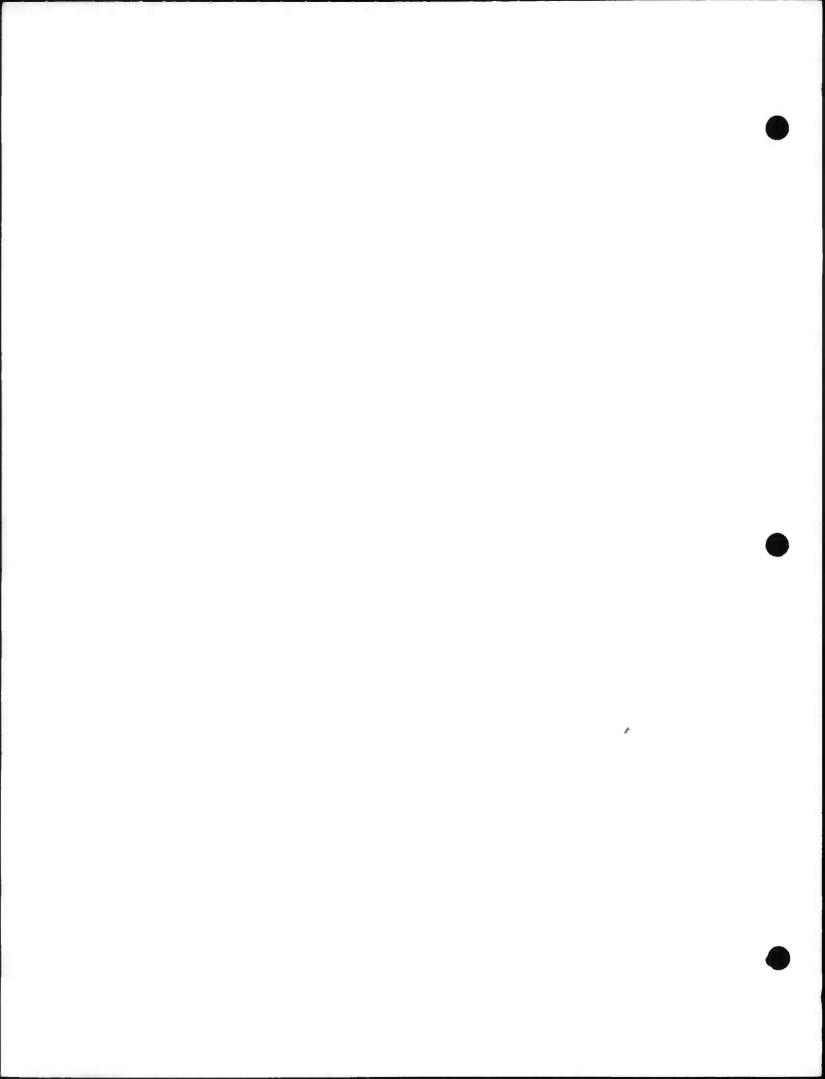


DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMP	COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
l examiner must be notified at once.	FTANT. If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
the funeral director, page 5 should be detached val.	FMEMAL DIFFCTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the state death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
er death. Page 6 may be retained by the hospi	HERPITAL OF ATTENDING PAYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi
DALLINORE, MARTEAND	

STATE OF MARYLAND / DEPARTMENT		MENTAL HYGIENE
CERTIFICATE	OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND M	MENTAL HYGIEN	E			
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
- 8	Dorothy	R.	Wi	1son		March 10,	1993 YEA	12:40 P M		
3	4. SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BI	IRTHPLACE (State or Foreign		
	293-14-3445	1 □ M 2 □ XF 7	O YRS.		10-51	11-21-192		Őhio		
DIRECTOR	94. FACILITY NAME (If not institution, give Physicians Memor			La Plat	R LOCATION OF OE	ATH	Sc. COUNTY C			
EC	10a. STATE 10b, COUNT	ГҮ	10c. CITY,	TOWN OR LOCATI	ON			10d. INSIDE CITY		
		narles	W	hite Pla				LIMITS?		
FUNERAL	10e. STREET ANO NUMBER				ZIP CODE		_	OF WHAT COUNTRY?		
R	Route 1 Box 212	Brookwood P1			20695		U.S.			
	1 Never Married 2 Married	FORCES? 1 YES	2 (10	If yes, spe	cify Cuban, Maxicar	IC ORIGIN? (Specify Year, Puerto Rican, etc.)		IACE — American Indian, Back, White, atc.		
ВУ	3 🔀 Widowed 4 🗌 Divorced	IF 1ES, GIVE WAR ON DE	AIES	1 YES	2 NO Specify		S	White		
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad	JCATION le completed)	16a. DECEDENT'S U	SUAL OCCUPATION	N t of working	16b. KIND OF BUS	INESS/INDUSTR			
9	Elementary/Secondary (0-12)	College (1-4 or 5 +)		rk done during mos retired.)	to normy					
Ř	12 17. FATHER'S NAME (First, Middle, Last)	0	Homemak	er		At H				
	Joseph Stautbe	2 24 (2				ME (First, Middle, Maiden				
H	19a. INFORMANT'S NAME (Type/Print)	:Ig	19h MAII ING A	DORESS /Street an	Flore	nce Mille Noute Number, City or Town		20605		
욘	Geraldine Mc Mi	illan						20695 Plains,M.D.		
	204-METHOD OF DISPOSITION	201	DIACEANDOATEOE	OICDODITION (No.						
	1 ABurial 2 Cremation 3 Ran 4 Donation 5 Other (Specify)	noval from State cerr	etary, crematory or other ary Land N	ational	Park Memoria	1 3-13-93	Laurel.	Maryland		
	21. SIGNATURE OF SUNEBAL SERVICE L	CENSEE		22. NAME AND	ADDRESS OF FAC	HLITY				
	1/1/5	he -				Funeral Ho		20904 Spring,M.D.		
	23. PART I. Enter the diseases, pr	complications that caused	the death. Do no	t enter the mod	le of dying, such	aa cerdlec pr reeple	retory arrest.	Approximata		
	shock, or heart fellure. IMMEDIATE CAUSE (Final	. List only one ceuse on e	ech line.			·	,	Interval Between Onset and Death		
	disease or condition a. Acute Lenhania									
	DUE TO (DR AS A CONSEQUENCE OF):									
NO N	Sequentially list conditions, Due to lor as a consequence op: Due to lor as a consequence op:									
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.										
띮	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):									
FR	resulting in deeth) LAST	d								
	PART II. Other significent condition	ns contributing to deeth b	ut not resulting in	the underlying	course alven in f	Part I. 24s. WAS AN	umanay I			
CAL	Peripheral	Action D	15egl	the diluenying	cades given in r	PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
G	7.1007	71.103	9000			1 YE\$ 2	NO	OF DEATH?		
Α.						_		1 YES 2 NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE DF DEATH (Check only one) 1 YES 2 NO 27. MANNER OF DEATH 28. DATE OF INJURY 28b. TIME OF 18c. INJURY AT WORK? WORK? WORK? 28d. DESCRIBE HOW INJURY OCCURED										
Sic	EXAMINER?	HOSPITAL: 1 Dinpatient 2 ER/Outp		OTHER:	5 - Residence 8	3 ☐ Other (Specify)				
듄	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c, INJU	RY AT	28d. DESCRIBE HOW IN	JURY OCCURED	,		
ВУ	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 YE	S 2 🗌 NO					
COMPLETED	3 Suicide S Could not be detarmined							rel Route Number,		
Ë	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my knowl	adne deeth occurred	of the time date of	ad alone and due t					
N N		ER: On the beals of examination						te(s) and manner as stated		
	29b. SIGNATURE AND TITLE OF CERTIFIE	4			29c. LICENSE NUM					
BE	13-2				D-233426		≥ 3	ED (Month, Dey, Year)		
2	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, P	rint) PO Bo	x 1724		-/	. 4 (7)		
	B. Larry Jenkins			I O DO		cyland 206	46	l		
ı	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA								
	MAR 17 '93	Julia Davidso	an Pandell							



	is marked, or Item 23 shows any injury, or other traumatic event, the medical exam
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	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF H	IEALTH AND	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Lest)	Wingate				2, DATE OF DEATH MONTH	MY	YEAR 5:25 A.M		
	4. SOCIAL SECURITY NUMBER	1 🗆 M 2 🔀 F	(In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1	BIRTHPLACE (State or Foreign Country) Washington DC		
TOR	90. FACILITY NAME (If not institution, give street and number) LO VIEN NUTSING CENTER COlumbia M RESIDENCE OF DECEDENT						9c. COUNT	Ward		
FUNERAL DIRECTOR		y gomery	10c. CI1	Y, TOWH OR LOCAT	ilver Spri	ng	10d. INSIDE CITY LIMITS? 1 🖾 YES 2 🗌 NO			
NERAL	12903 Kilgore Roa							EN OF WHAT COUNTRY?		
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3.A.X.Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 TYES IF YES, GIVE WAR OR D	N U.S. ARMED 2 XNO PATES	If yes, sp	ENDENT OF NISPA ecify Cuban, Mexic 2 NO Speci	NIC ORIGIN? (Specify Yean, Puerto Rican, etc.)	e or No—	4. RACE — American Indian, Black, White, etc. Specify: White		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementery/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give kind of life. Do NOT u	USUAL OCCUPATION work done during mo se retired.) Cration	est of working	16b. KIND OF BU				
COM	17. FATNER'S NAME (First, Middle, Last)		Administ	racion A	18. MOTHER'S N	AME (First, Middle, Maiden Surreme)				
BE	August Spigone 190. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a		s Giardina Route Number, City or Tox	- Ol-to 7/o 0			
5	Jack Maio					ver Spring		ode)		
	20e. METNOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remaid 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNCTION	cen Fo	o.PLACE ANODATE	oln .	3/13/93	Br		ty or Town, State		
	Hines-Rinaldi F.H. Inc 11800 New Hampshire Ave, Silver Spring, M									
	28. PART I. Enter the diseases, or of ahock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Liet only one ceuse on e	d tha desth. Do sach line.	on the mo	de of dying, aud	the e cerdlec or resp	ratory arrea	Approximata interval Between Onset end Death		
LION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (Disease or injury)									
CERTIFICATION	cause, Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	OUE TO (OR AS A	CONSEQUENCE OF	F): (-	zilu	e				
		1,	Vit	() ()						
PHYSICIAN: MEDICAL	PART II. Other significent condition	e contributing to death b	ut not resulting	in the underlying	g ceuse given in	Part i. 24e. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
ICIAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		28. PL	ACE OF DEATH (Ch	neck only one)				
HYS	1 YES 2 NO 27. MANNED OF DEATH	t Inpatient 2 ER/Outp	atlent 3 DOA	4 Nursing Nome		6 Other (Specify) 28d. OESCRIBE NOW I	HIER OCCU	050		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		URY WO	RK?	280. DESCRIBE NOW I	NJORY OCCUP	TED		
	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	— At home, ferm, a	street, fectory, office		261, LOCATION (Street of City or Town, Stete)	and Number or	Rural Route Number,		
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my showed the course of the classical stat									
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	V		29c. LICENSE NUI	2. 4 b	SIGNED (Mogth, Day, Year)				
	30. NAME AND ADDRESS OF PERSON WHO Charles Sheehan				Pike. El	llicott Cir	v. MD	21042		
Charles Sheehan 10298 B. Baltimore National Pike, Ellicott City, MD 21042 31. DATE FILED (Month, Day, Near) 32. REGISTRAR'S SIGNATURE ARR 17 93							-1072			

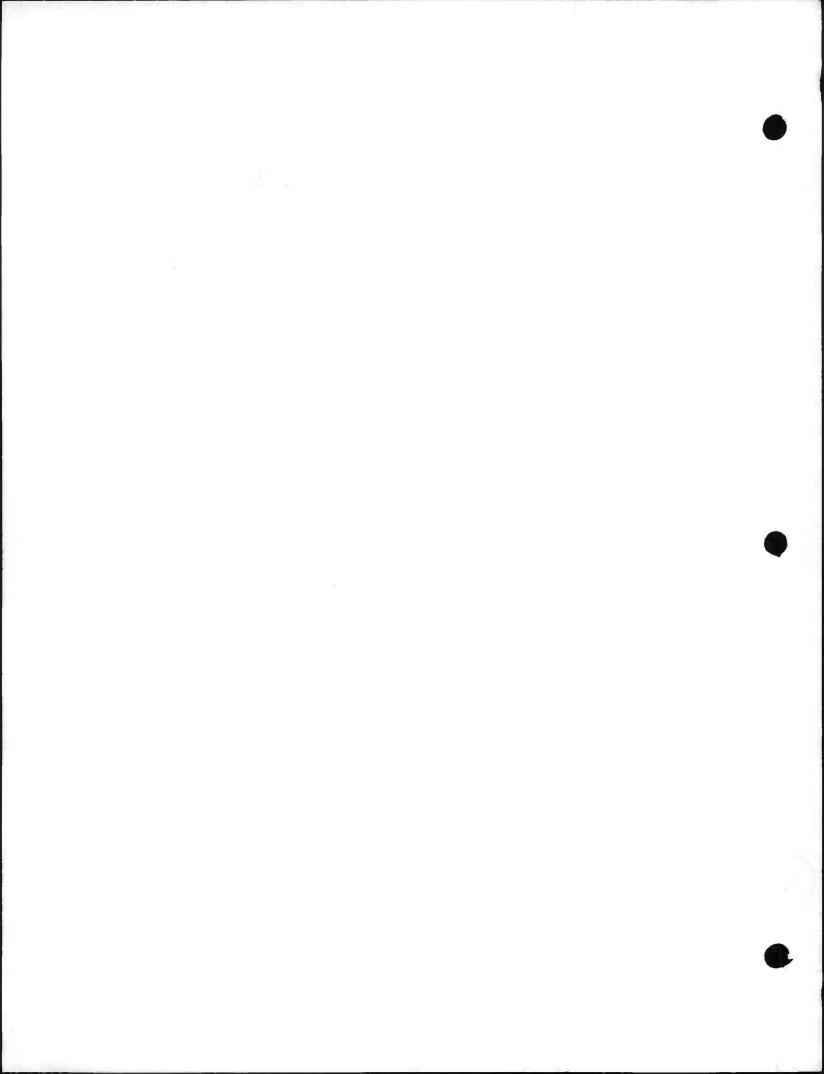
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If I lem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death, Page 6 may be retained by the hospital or attending physician.

STATE	0F	MARYLAND A	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
		C	ERTIFICATE	0	F DEAT	H		BEG NO

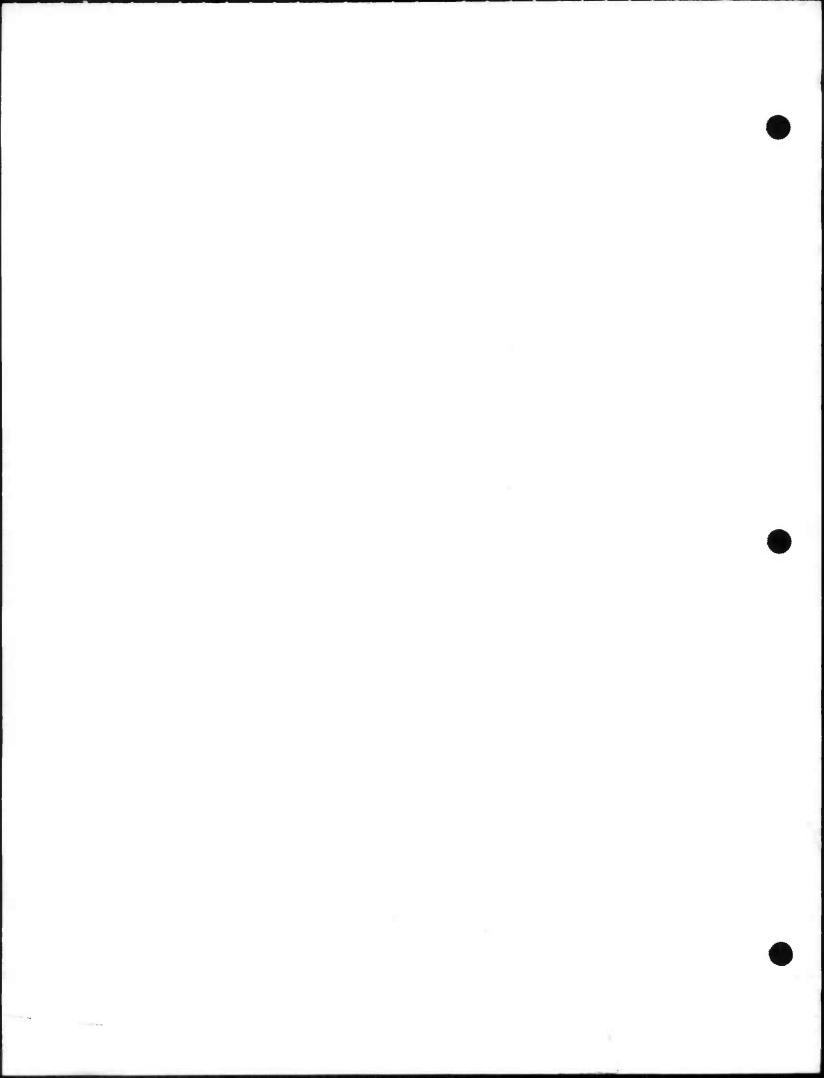
	1 - FOR STATE REGISTRAR		STATE OF MARYL		RTMENT OF		MENTAL HYGIEI		000004
- 6	1. DECEDENT'S NAME (First, A	Middle, Last)	STANLEY P	ROBERT V	ITLLTAMS		2. DATE OF DEATH		3. TIME OF DEATH
	Starley!	. Wil	lans		, 12211410		монтн 03 ~	18 -9	3 12:10 am "
	4. SOCIAL SECURITY NUMBER			In yrs. last birthday)		IF UNDER 24 HRS.	7. DATE OF BIRTH	8.	BIRTHPLACE (State or Foreign
- 0	215-44-825	6 1	₩2 □ F 84	YRS.	MONTHS DAYS	HOURS MIN.	MAY 21,		Country) ASHINGTON
	9a. FACILITY NAME (If not insti				9b. CITY, TOWN	OR LOCATION OF D		9c. COUNTY	
۳	HOLY CDOCC II	OCDIMAI							
HOLY CROSS HOSPITAL SILVER SPRING MONTGOM RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MARYLAND MONTGOMERY SILVER SPRING MONTGOMERY SILVER SPRING								GOMERY	
								10d. INSIDE CITY	
MARYLAND MONTGOMERY SILVER SPRING									LIMITS?
4	10e. STREET AND NUMBER					H. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
100. STREET AND NUMBER 101. ZIP CODE 102. CITIZEN OF WHAT (USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE—A in 15. Was december of Hispanic Origins, edg.) 14. Namer Marriad 2 Northol 15. Namer Marriad 2 Northol 16. Namer Marriad 2 Northol 17. Namer Marriad 2 Northol 18. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE—A in 15. Was december to the name of							ΙΙς Δ		
3	11. MARITAL STATUS		2. WAS DECEDENT EVER I	U.S. ARMED	13. WAS DE	CENDENT OF HISPAI	NIC ORIGIN? (Specify Y		RACE - American Indian
	1 Never Married 2 M		FORCES? 1 X YES			pecify Cuban, Mexica S 2 A NO Specific	in, Puerto Rican, etc.)		Black, White, etc. Specify:
B	3 🔀 Widowed 4 🗌 Divorce	ed						l W	HITE
	15. DECED (Specify only h	DENT'S EDUCAT	TON mpleted)	(Ghm kind of	S USUAL OCCUPAT work done during m	ION ost of working	166. KIND OF BI	USINESS/INDUST	TRY
1	Elementary/Secondary (0-1)	2)	College (1-4 or 5+)	Me. Do NOT	use retired.)				
COMPL			4	OFFICIA	L		DEPT.	OF AGRI	CULTURE
8	17. FATHER'S NAME (First, Midd	die, Last)				18. MOTHER'S NA	ME (First, Middle, Maide	n Sumame)	
98	DAVID OWEN		AMS			SARA E	DITH JAME	S	
0	194. INFORMANT'S NAME (Type	e/Print)		19b. MAILIN	G ADDRESS (Street	and Number or Rural	Route Number, City or To	wn, State, Zip Coo	de)
-	DAVID O. WI		(SON)	605 E	ENNINGTO	ON LANE	SILVER SP	RING, M	ARYLAND 20910
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation		I from State 20b	PLACE AND DATE	OF DISPOSITION (A	ame of	DATE 20c. L	OCATION — City	or Town, State
	4 Donation 5 Other			ETROPOLI	TAN CREI			XANDRIA	,VIRGINIA
1	21. SIGNATURE OF FONEMAL	SERVICE LICEN	BEE / / ///	11		ND ADDRESS OF FA	LINS FUNE	DAT HOM	E INC
	Make	1	1/2000	h					R.,MD.20901
	23. PART I. Enter the dise	eases, or con	pilcations that cause	the death. Do	not enter the m	ode of dying, suc	h as cardiac or resi	piratory arrest.	Approximate
- 1	shock, or heart failure. List only one cause on each line.								interval Between Onset and Death
H	disease or condition		RESPIRATO	es lases	PRUENCE	7			
ï	resulting in death)	8.,	RESPIRATS	CONSEQUENCE	OF):				1 hoin
z		- A	BILLY 181221	PNEUMON	is				3 days
HILICATION	Sequentially list condition if any, leading to immedia	ate	DUE TO (OR AS	CONSEQUENCE	DF):				/ 4
5	cause. Enter UNDERLYING CAUSE (Disease or Injury								
=	that initiated events resulting in death) LAST		DUE TO (OR AS A	CONSEQUENCE	DF):				
ш	resolding in death) LAST	d	<u> </u>						
2	PART ii. Other significant	conditions	contributing to death b	ut not resulting	in the underlying	g cause given in	Part I. 24a. WAS A	N AUTOPSV	24b. WERE AUTOPSY FINDINGS
5	Line Cancer				,	,	PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDIC							1 YES	2√□ NO	OF DEATH?
Σ	Parent Col	CA ()					—		1 TYES 2 NO
A I	25. WAS CASE REFERRED TO I	MEDICAL							
2	EXAMINER?	Н	OSPITAL:		OTHER:	LACE OF DEATH (Ch			
<u>"</u>	27. MANNER OF DEATH	;	Inpatient 2 - ER/Outp	atient 3 DOA		ne 5 Residence			
١ -	1 Natural 5 Pe		(Month, Day, Year)	l in	JURY W	JURY AT DRK? YES 2 NO	28d. DEŞCRIBE HOW	INJURY OCCURI	ED
5	2 Cutate	restigation	3-18-73 284. PLACE OF INJURY				204 LOCATION (Over		
3	~	ould not be termined	building, etc. (Spec	ify)	actives, nectory, orne	2	281. LOCATION (Street City or Town, State	and Number of F	sural Houte Number,
MPLEIEU	29a. CERTIFIER	VINO							
È			N: To the best of my know						
3	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, deta and place, and due to the cause(a) and manner as stated.							Ruse(a) and manner as stated.	
	296. SIGNATURE AND TITLE O	GENTIFIER	- ~	W/kg	12 lus	29c. LICENSE NUI	MBER	29d. DATE SI	GNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF P	MARKET OF	OMBI ETED CAUSE OF ST	ATM OTEN OF		700	38	3/0	8/93
	Para S C		5 11 1		esi Sizi	86n beeps	· Wo		
	31. DATE FILED (Month, Day, Yes	MARUK	32. REGISTRAR'S SIGN		AC 7436	Garbon	pr Side	ind I we	20910
	MAR 19	93	Julia Davido	man Prode	2				
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2	HYSIC	
DIMINION OF VILAL RECORDS, P.O. BOX 88/60	AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death	
	S.	
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			has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.	
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	BALTIMORE, MARYLAND 21215-0020	leath.	funera	xamir
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		in 24	has been signed by the attending physician and completely filled in by the it bept, of Health and Mental Hygiene prior to burtal, cremation, or removal,	п 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	OR	s that	ned by	any
	3EC	equire	en sig of Hea	hows
	Y.	WE S	has be Dept.	23 s
	TI/	N: The	State S	Item
	JF V	YSICIA	s certi	d, 0
and Nation	Z	NG PH	ter this	татке
0	MISTON OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate be filed within 72 hours after death with the State	APORTANT: If Item 28 is marked, or Item
	1	OR AT	OURS at	еш 2
		PITAL (RAL C	E If It
	1	HOSP	FUNE	TANT
914.41	Yelps	O THE	THE Filed	MPO
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1	1			

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL	HYGIEN				
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	F DEATH DA		WEAR	3. TIME OF DEAT	Н
	EDWARD F. WAR					н 13,		YEAR	12:50	Рм	
	4. SOCIAL SECURITY NUMBER 5	IF UNDER 1 YEAR	IF UNDER 24 HRS.	The state of the s					reign		
	150-16-7482	66 YRS.	MONTHS DAYS	HOURS WIN.	OCT.1		N		JERSEY		
~	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF							9c. COUNT	Y OF D	EATH	
DIRECTOR	9803 BELHAVEN ROAD BETHESDA MONTGOMERY								MERY		
EC	100. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	TION				10d. INSIDE CITY		
DIR	MARYLAND MONTGO	MERY		BETHE	AUS VUS					LIMITS?	
AL	10e. STREET AND NUMBER				. ZIP CODE			10g. CITIZE	N OF W	HAT COUNTRY?	
FUNERAL	9803 BELHAVEN ROAD)			20817				US	2 A	
5		FORCES? 1 X YES		13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN?	Specify Yes	or No-	4. RACE	- American India	ın,
BY	1 Never Married 2 X Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DAT			ecify Cuben, Mexico 2 NO Specif		an, atc.)		Specif	, White, etc.	
	15. DECEDENT'S EDUCAT	WW II	Ma DECEDENTIA	Hellar Coourner					JHI	ľE	
E	(Specify only highest grade con	npleted)	(Give kind of v	VORK done during mode retired.)	on st of working	16b. K	IND OF BUS	INESS/INDUS	STRY		
7	Elementary/secondary (0-12)	College (1-4 or 5+)		ENGINEER							
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		SISIEM I	SNGINEER	18. MOTHER'S NA			GOVEI	KNMF	INT	
BE C	JOSEPH WARES				JULIA		RUZZT	,			
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a.	nd Number or Rural			, State, Zip C	ode)		
F	DOLORES A. WARES	(WIFE)	9803 E	BELHAVEN	ROAD B	ETHESI)A. M	ARYI.AN	JD	20817	
	20a. METHOD OF DISPOSITION 1 ◯ Burlal 2 □ Cremation 3 □ Removal	from State came		F DISPOSITION (Ne		OATE		CATION - CH			
	4 Donation 5 Other (Specify)	G	ATE OF F	IEAVEN C		3/18	SIL	VER SE	PRIN	G MARYL	AND
	21. SIGNATURE OF FUNERAL SERVICE LICENS))))	4.4	FRANC	IS J. CO	CILITY					
	Umothy	2/Carple	ll	500 U	NIVERSIT	Y BLVI	W.	STI. S	PR	MD 209	01
	23. PART i. Enter the diseases, or com shock, or heart fellure. List	iplications that caused	the deeth. Do n	ot enter the mo	de of dying, auc	h as cerdle	c or reapli	atory arres	it,	Approxime	ete
	IMMEDIATE CAUSE (Final	1 00								Onset and	
	disease or condition a. DOFT TISSUE SARROWA 6 MOS								20		
	DUE TO (OR AS A CONSEQUENCE OF):										
ON	Sequentially list conditions, b	DUE TO (OR AS A C	ONSEQUENCE OF								
Ă	if any, leading to immediate cause. Enter UNDERLYING	00E 10 (0N A3 A C	ONSECOENCE OF	1:							
필	CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A C	ONSEQUENCE OF):						-	
CERTIFICATION	resulting in death) LAST										
	PART ii. Other algnificent conditions conditions	ontributing to death but	not regulting I	n the underlying	anne elue le	Post I I a					
CAL	THE PERSON OF TH	onthousing to deeth but	t not recurring i	n the underlying	cenee diveu iu		PERFORI	WEO?		WERE AUTOPSY FII	то
EDI						_ 1	YES 2	NO NO		COMPLETION OF C OF DEATH?	AUSE
Σ										1 YES 2 N	10
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			28. PL	ACE OF DEATH (Ch	ack only one)					
Sic		OSPITAL: Inpetient 2 ER/Outpat	ient 3 🗆 DOA	OTHER:	1	8 Other (S					\neg
Ŧ	27. MANNER OF DEATH	28e. DATE OF INJURY	28b, TIME	OF 28c. INJU	JRY AT			JURY OCCUI	REO		-
BY F	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Yeer)	ILNI		RK? ES 2 NO						[
	3 Suicide S Could not be	28e. PLACE OF INJURY — building, etc. (Specify	At home, ferm, s	treet, factory, office	,	28f. LOCATI	ON (Street ar	nd Number or	Rural Ro	oute Number,	
	4 Homicide determined					City or	own, State)				
F	290. CERTIFIER Check only CERTIFYING PHYSICIAN	N: To the best of my knowled	ige, death occurre	d at the time, date	end plece, end due	to the cause	(e) end men	ner ee stated.			
81	2 MEDICAL EXAMINER: O	on the basis of examination e	end/or investigation	n, in my opinion, de	eath occured at the	time, date en	d place, end	due to the o	euse(e)	end menner ee st	ated.
BECOMPLETED	29h. SIGNATORE AND TITLE OF CENTIFIER		\		29c. LICENSE NUN	ABER _		29d. DATE	IGNEO (Month, Day, Year)	$\overline{}$
0	gemes a. Bol	sever UU	(N		0072	82		▶ 3/	17/	93	f
-	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEAT	H (ITEM 27) (Type,	Print)	1		0		1		
	YAMES A. ISO	DUN MU	1480	8 THYS	ICAANS 4	ANE !	SCKV	ILLE	ALD	20850	
	31. DATE FILED (Month, Dey, Year) 32. REGISTRAR'S SIGNATURE MAR 18 '03 Action Mark 18 '03										
	THAT I O A'S	Tuna Dandra	Audianda 82								- 1



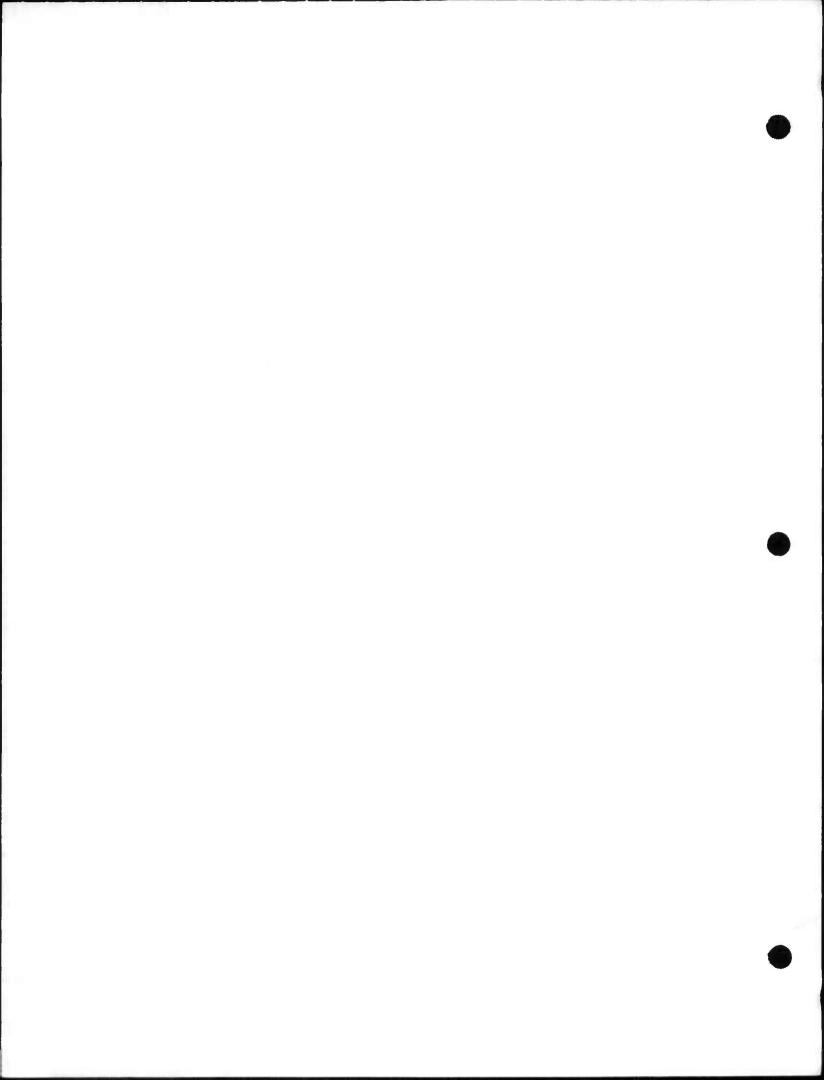
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	HYSICIAN: The law requires that the death certificate be executed within 24 frours after death. Page 6 may be retained by the hospital or attending physician,	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit Panes 1.2.3 should	th the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	id, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	e law requires that the	has been signed by the	Dept. of Health and Mr	23 shows any inju
	DING PHYSICIAN: Th	After this certificate	if death with the State	Is marked, or iten
(THE HIS PITE OR TTE	THE FUMICIAL DIRECTOR	filed within	PORTANT: If Item 28
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2000	CH
	IN OTTO

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPART			MENTAL	HYGIENI REG. NO.	E		
	1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF			3. TIME OF DEATH	
	HILDA E.	WETZER				MARCE	1 16,		9:35 P M	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER t YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH								BIRTHPLACE (State or Foreign	
	078-05-3696	□ M 2 X F 79	YRS.	ONTHE DAYS	HOURS MIN.		3,191		Country) IEW YORK	
	9a. FACILITY NAME (If not institution, give stree		9	b. CITY, TOWN O	R LOCATION OF D		3,171	9c. COUNTY		
DIRECTOR	COLLINGTON EPISCOPAL LIFE CARE CTR. MITCHELLVILLE PRINCE GEORGE									
10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY	
	MARYLAND PRINCE	GEORGE	НУА	TTSVILL					LIMITS? 1 YES 2 NO	
FUNERAL	The Charles of the State			101.	ZIP COOE			10g, CITIZEN	OF WHAT COUNTRY?	
3450 TOLEDO TERRACE 20782								USA		
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — A Black, Wh								RACE — American Indian, Black, White, etc.		
ВУ	3 Widowed 4 N Divorced	IF YES, GIVE WAR OR OATE	S	1 🗌 YES	2 NO Speci	y.			Specify:	
	15. DECEDENT'S EDUCAT	TION 16	e. DECEDENT'S US	UAL OCCUPATIO	M .	18b K	IND OF BUILD	IWH INESS/INDUST	ITE	
E	(Specify only highest grade cor	mpleted) College (1-4 or 5 +)	(Give kind of wor life. Do NOT use I	k done durina mos	it of working	1002. K	IND OF BOSI	MESS/INDUS I	NY	
7			MINISTR	ለጥፐፕፖር ለ	C C T C T A NT	P 7.7	C (10)	RNELL	00	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	<u> </u>	MILINIDIN	ALIVE A	18. MOTHER'S N					
	CONRAD WETZ	7 F D								
8E	19a, INFORMANT'S NAME (Type/Print)	SER	19b. MAJLING AL	ODRESS (Street a	PAUL :		ROED:		(5)	
2	D.W. FITZGIBBONS									
	20a. METHOD OF DISPOSITION	20h PI	ACEAND DATE OF		ERRACE	PATE			LAND 20782 or Town, State	
	1 Donation 5 Other (Specify)	of from State cometer	y, crametory or other ROPOLITA	piace)	ATODV	1			W. E. Linea	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE	ROLOLITA		O ADDRESS OF F		ALEA	ANDRIA	, VIRGINIA	
	▶ 1· 11 0	40 11)		S J. COI					
-	umothyx	1. Campbell		500 UN	IVERSITY	BLVD	.,W.	SIL.SP	R.,MD.20901	
	23. PART I. Enter the diseases, or com- shock, or heart fellure. Lie	nplicatione that caused that only one cause on each	a death. Do not line.	enter tha mod	de of dyling, aud	ch as cardle	c or reepin	etory erreet,	Approximate Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	march and	1 -21				0 0		Onset and Death	
	resulting in death)	meras	anc.	OV	ana	n	ar	cer		
	DUE TO (OR AS A CONSEQUENCE OF):									
8	Sequentially list conditions, b	DUE TO (OR AS A CO	NEEDHENOT OF							
F	if any, leading to immediate cause. Enter UNDERLYING	DOE TO JON AS A CO	NSECUENCE OF):							
윤	CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A CO	NSEQUENCE OF:							
CERTIFICATION	resulting in death) LAST	222 10 (01111211 00								
8	d									
AL	PART II. Other algnificant conditions c	contributing to death but i	not resulting in	the underlying	ceuse given in	Part I. 2	la. WAS AN A		24b. WERE AUTOPSY FINDINGS	
8						_	PERFORM	The second	COMPLETION OF CAUSE	
W									OF DEATH?	
ž						_		1	7 120 2 110	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PL	ACE OF DEATH (C)	eck only one)				
Sic		OSPITAL:		THER:	5 - Residence	8 Other (S	ipecify)			
至	27. MANNER OF GEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME C	F 28c. INJL	IRY AT			JURY OCCURE	ED .	
BY	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Tear)	RULNI		ES 2 NO					
	3 Suicide 6 Could not be	26s. PLACE OF INJURY —	At home, term, atre	et, factory, office		28t. LOCATI	ON (Street an	d Number or R	ural Floute Number,	
29a. CERTIFUE Check only one) 29a. CERTIFUE Control of the determined Certifue of the cause of the control of the cause of the cau										
<u>\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ </u>	one) 2 MEDICAL EXAMINER: C	On the beals of examination an	d/or investigation, i	n my opinion, de	eth occured at the	time, data an	d place, and	due to the co-	use(s) and menner as stated	
	29b. SIGNATURE AND TITLE OF CERTIFIER	-								
8	VI DILLO CX	and un			29c. LICENSE NUI	MBER 1		29d, DATE SIG	INED (Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH	(ITEM 27) (5 2-	int)	Tap.	57.1		3	[1/[7]	
	MARCIA KANE, M.D.	7243-A HANO	VER PARK	WAY GI	REENBELT	, MD.	20770)		
12	31. DATE FILED (Month, Day, Year)	Julia Davidson								



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		FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAI	RTMENT OF	F HEALTH AND OF DEATH		YGIENE EG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF E	DEATH	3	. TIME OF DEATH	
		LINDA WALLS					03	80	93	11:10 Pm	
		4. SOCIAL SECURITY NUMBER 216-64-1167		n yrs. last birthday)	MONTHS DAY		7. DATE OF 8 (Month, De	r, Year)	8. BIRTHPL Country)	ACE (State or Foreign	
bluo		9a. FACILITY NAME (If not institution, give si	Δ.	32 YRS.	Sh CITY TON	WN OR LOCATION OF	Oct.7,			yland	
1, 2, 3 should	DIRECTOR	Greater Laurel-Be		pital	Laur		DEATH		CE GE	orge's	
	REC	10a. STATE 10b. COUNTY		10c. CI1	TY, TOWN OR LO	OCATION			1/	od. INSIDE CITY	
permit. Pages	AL DI	Maryland Princ 100. STREET AND NUMBER	e George's	B	Ladensb	urg 10f. ZIP CODE	10- CITIZEN OF			LIMITS? VYES 2 NO AT COUNTRY?	
ışı	IER.	4201 53rd Avenue	#1			20710			.S.A.		
21215-0020 al or attending physician. for use as the burial-transit	BY FUNER	11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO If YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISP. If yes, specify Cuban, Maxk 1 ☐ YES 2 ☒ NO Specify Cuban, Maxk 1 ☐ YES 2 ☐ YES 2 ☐ YES 2 ☐ YES 2 ☐ YES 2 ☐ YES 2 ☐ YES 2 ☐ YES 2 ☐ YES 2 ☐ YES 2 ☐			PANIC ORIGIN? (Specify Yes or No— 14. RACE — American, Puerto Rican, etc.)			Vhite, etc.		
215 attend	ED	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S	USUAL OCCUP	ATION	16b, KIN	D OF BUSINESS/IND	USTRY	4	
	9	Elementary/Secondary (0-12)	College (1-4 or 5+)	Careta		most of working		000			
by the hospital be detached to at once.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)	2	Careta	rver	and the second of		.O.C.A.			
8 8 E		Charles H. Wall	5				n P. Przybysz				
MARYLAND retained by the hospit should be detached notified at once.	TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stre		ural Route Number, City or Town, State, Zip Code)				
	۴	13211 Croolli Rd., Brandywine, Maryla								13	
BALTIMORE, ter death. Page 6 may be the funeral director, page wal.		20a. METHOD OF DISPOSITION 1 X Burlal 2 Cramation 3 Remo	oval from State come	PLACE AND DATE tery, crematory or o	ther place)		DATE	20c. LOCATION — C			
Page Il direc		4 Donation S Other (Specify): 21. SIGNATURE OF FUNERAL SERVICE LIC	HOT	y Rosar		tery 3-1		Baltimon	re, M	aryland	
ALTIMOR death. Page 6 ma e funeral director, pd. examiner must		N/ //	11/2-1-		Rende	on/Hale L	anham F	uneral Ho	ome_		
BA hours after d d in by the or removal.	_	23. PARK L Enjey the diseases, or o	omplications that caused	the deeth. Do	not enter the	Annapol	IS Rd.,	Lanham, Ma	irylai	nd 20706	
DO DO E		impok, or heaft failure. I	ist Dnly Dne ceuse on ee	ch ilne.				or respiratory and	rutg	interval Between Onset and Death	
hin 24 in tely fille mation, t, the		disease or condition resulting in death)	Pulm	MANDE	21 0	mboli	for .				
68760, ecuted within and completely burial, crema			DUE TO (OR AS A	CONSEQUENCE O	D.						
OX 687 e be executed sician and con nor to burial, traumatic er	ON	Sequentielly list conditions,	DUE TO (OR AS A	CONSEQUENCE O	ค:						
30) site be prior trau	CAT	if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury									
P.O. BOX th certificate be extending physician at Hygiene prior to or other traum	E	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):						
OS, P.O. Both death certificate the attending physical Mental Hygiene principle, or other the principle.	CERTIFICATION	rooming in death) Exo	1.								
그 음 등 글	4	PART II. Other aignificant conditions	contributing to deeth bu	t not resulting	in the underi	ying ceuse given i	n Part i. 24a.	WAS AN AUTOPSY		ERE AUTOPSY FINDINGS	
RECORI requires that the een signed by of Health and shows any in	EDIC						10	PERFORMED? YES 2 X NO	CC	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?	
# 5 5 5 E	M								1	YES 2 NO	
Law that the Coept 23	AN	25. WAS CASE REFERRED TO MEDICAL			200	. PLACE OF DEATH (C					
- F 2 8 3	PHYSICIAN	EXAMINER?	HOSPITAL:	tient 3 DOA	OTHER:	tome 5 Residence					
OF VI	PH	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. T/M		INJURY AT WORK?		E HOW INJURY OCC	URED		
	βÁ	1 Netural 5 Pending 2 Accident Investigation			M 1 [YES 2 NO					
N F F F F F F F F F F F F F F F F F F F	ETED	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY - building, etc. (Specif	— At home, farm, : y)	street, factory, o	iffica	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			Number,	
0 9 7 2 3	COMPL		CIAN: To the best of my knowle								
TO THE HOSPITAL TO THE MINING TO MPOSTACE. II	A111	29b. SIGNATURE AND TITLE OF CERTIFIER	R: On the basis of examination	and/or investigation	on, in my opinio			place, and due to the	cause(a) ar	nd manner as stated.	
某某事	H	Salana La	en X 6-5			29c. LICENSE NU	IMBER	29d. DATE	SIGNED (M	onth, Day Year)	
무 유 품 볼	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	ГН (ITEM 27) (Туре	. Print	12-17	ava	1 0	110	175	
		73/3 Stran	er Phesy	rA.	The	embell	X A	150	777		
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	TURE				11.			
		MAR 1 1 1993 4	ina Davidson-Mar	phell							

BALTIMORE, MARYLAND 21215-0020 ON OF VITAL RECORDS, P.O. BOX 68760,

After this certificate has death with the State De i marked, or item 2 ING PHYSICIAN

PHYSICIAN: MEDICAL CERTIFICATION

BY

COMPLETED

BE

2

#

23

25. WAS CASE REFERRED TO MEDICAL

5 Pending investige

6 Could not be

1 YES 2 NO

27. MANNER OF OEATH

1 Natural

2 Accident
3 Suicide

4 Homicide

TOHN

the law requires that the death certificate be executed within 44 hours after death. Page b may be retained by the hospital or afterding physician. The bas been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit te Dest. of Health and Mental Hygiene prior to burial, cremation, or remoting rector, page 5 should be detached for use as the burial-transit te Dest. or Health and Mental Hygiene prior to burial, cremation, or remoting examiner must be notified at once.	hysician.	urial-transit		
he law requires that the beam certificate be executed writin 44 hours after beam. Page 6 may be retained by the hospital set has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to the Dept. of Health and Memial Hygene prior to build, cremation, or removal. The strong any injury, or other traumatic event, the medical examiner must be notified at once.	or attending p	r use as the b		
the law requires that the beam certificate be executed writin 44 hours after beam. Page 6 may be retained by the has been signed by the attending physician and completely filled in by the funeral director, page 5 should be to bear. of Health and Memiat Hyghene prior to burial, cremation, or removal. The stowns any injury, or other traumatic event, the medical examiner must be notified at	the hospital	detached for		once.
he aw requires that the bean certificate be executed writin 24 hours after bean. Page 6 may be that been signed by the attending physician and completely filled in by the funeral director, page to Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. The stower any injury, or other traumatic event, the medical examiner must be in the control of the control	retained by	5 should be		notified at
ne law requires that the earth centralists be executed within 24 hours after death. Fall see has been signed by the attending physician and completely filled in by the funeral of the Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. The Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. In 23 shows any Injury, or other traumatic event, the medical examines	3e 6 may be	irector, page		must be
he aw requires that the death centheate be executed writin 24 hours and the axeen signed by the attending physician and completely filled in by the 20 bebt. of Health and Mental Hyglene prior to burist, cremation, or remover m 23 shows any injury, or other traumatic event, the medical	r death. Pa	he funeral d	- F	examine
ne aw requires nat ne dean cerimizate de executed writint se e has been signed by the attending physician and completely if the Dopt. of Health and Mental Hygiene prior to burtal, cernation m 23 shows any Injury, or other traumatic event, th	4 nours are	illed in by ti	n, or remov	e medical
ne law requires that the deam certificate be executed the partial physician and cite. Deep consistency of health and Mental Hygiene prior to buring m 23 shows any injury, or other traumatic.	DO WITHIN 2	ompletely fi	al, crematio	event, th
ne law requires that the obstit certificate has been signed by the attending physic Dept. of Health and Mental Hygiene pm. 23 shows any injury, or other	e de execut	sician and c	rior to buri	traumatic
ne law requires that the deal has been signed by the att is Dept. of Health and Merita m 23 shows any Injury,	in ceruncat	ending phy	Hygiene p	or other
e has been signed to Dept. of Health m 23 shows an	nat the oea	the att	and Menta	ny injury,
e has te Dep	v requires t	been signer	t. of Health	shows a
	ne lav	e has	te Dep	m 23

permit. Pages 1, 2, 3

FUNERAL

BE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH 1993 John Gerald White March 2:00 A.M.M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH
(Month, Day, Year)
Jan. 5 1900 IF UNDER t YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 200 07 7553 Beaver Falls Pa 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR 12202 Tilbury Lane Bowie Prince George's RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's XX YES 2 NO 10a. STREET AND NUMBER 101, ZIP CODE 12202 Tilbury Lane 20715 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 KNYES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married ВҰ 1 YES 2 X NO Specify: **3** ₩Idowed 4 Divorced No White COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade dary (0-12) College (1-4 or 5+) Diary Store Self Employed 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) John White Mary Kirkwood 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) William John White 12202 Tilbury Lane Bowie Md. 20715 20s. METHOD OF DISPOSITION
1X Removal from State
4 Donation 5 Disposition 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Sista cemetery, cremetory or other place)
Mt. Carmel Cemetery 3/10/93 Pittsburgh Pa 22. NAME AND ADDRESS OF FACILITY
Beall-Evans Funeral Home, P.A. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kober 100 16000 Annapolis Rd. Bowie Md. 20715 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ae cerdiac or reepiratory arrest, Approximate shock, or heart fellure. List only one ceuse on each line. Interval Between **IMMEDIATE CAUSE (Finel** Onset and Death disease or condition_ CONCESTIVE HEART FAILURE . ADVANCED 3 YEARS resulting in deeth) ATHEROSCLEROTIC HEART PISEASE Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury PEQLIPEDEMIA DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PERTENSION

PART II. Other eignificent conditione contributing to death but not reaulting in the underlying cause given in Pert i.

HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA

26a. DATE OF INJURY (Month, Day, Year)

24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO

261. LOCATION (Street and Number or Rural Route Number, City or Town, State)

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO

26. PLACE OF DEATH (Check only one) OTHER: 4 Nursing Home 5 Realdence 6 Other (Specify)

01046

28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, streel, factory, offica building, atc. (Specify)

29e. CERTIFIER
(Chack only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

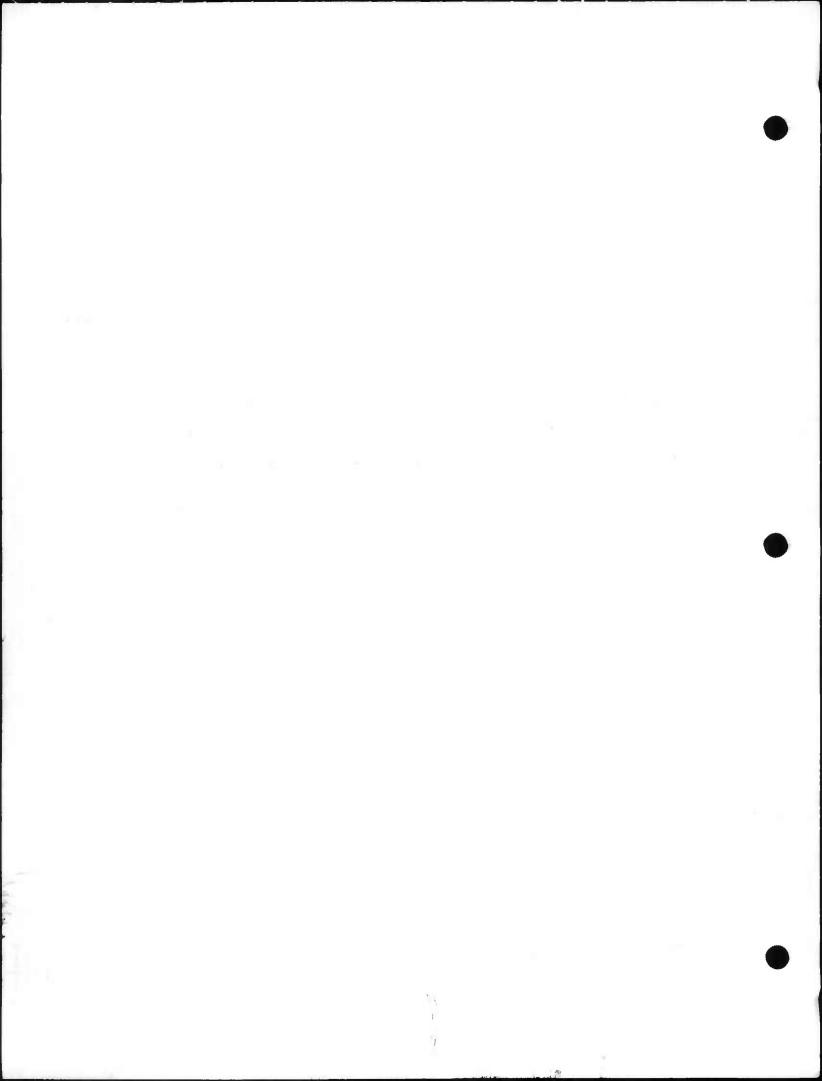
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIEF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

ea 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

> 4000 MITCHEL VILLE 32. REGISTRAR'S SIGNATURE

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DIVISION OF VITAL RECORDS, P.O. BOX 6876U,

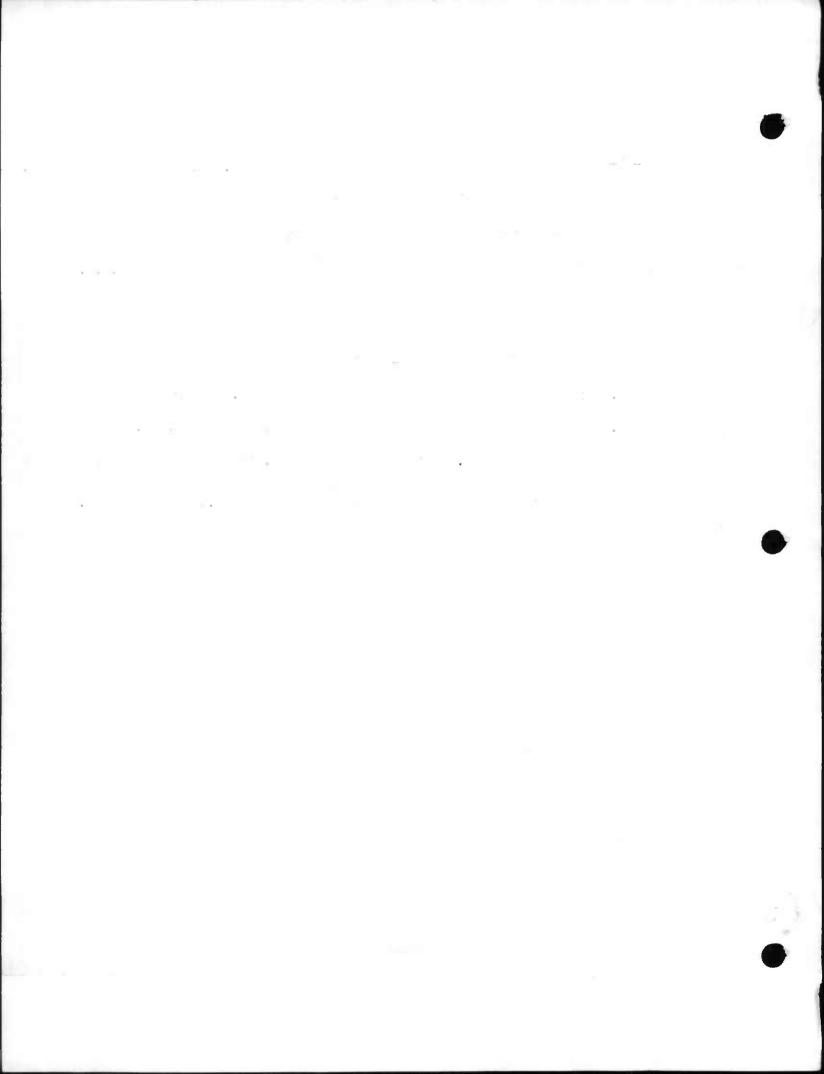
TO HE HOSPITAL DR ATTENDING PHYSICIAN: The law resulters that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO BE COMPLETED BY FUNETRAL State Deep critical has been signified and principlent within 27 hours. It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE	OF MARYLAND / DEPARTMENT	OF HEALTH AND	MENTAL HYGIENE
	CERTIFICATE	OF DEATH	REG NO

	FOR STATE REGISTRAR	STATE OF MARYLAN		NT OF HEALTH AND TE OF DEATH	MENTAL HYGIE						
01	1. DECEDENT'S NAME (First, Middle, Last) ANNE EAZ		lizabeth	WEIGLE	2. DATE OF DEATH MONTH	DAY 2	3. TIME OF DEATH				
6	4. SOCIAL SECURITY NUMBER 213-62-2527	5. SEX 6. AGE (in) 1 M 2 F 31		DER 1 YEAR F UNDER 24 HRS. B DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct. 28,	1961	BIRTHPLACE (State or Foreign Country) Washington D.				
or.	9a. FACILITY NAME (If not institution, give s		9b. C	ITY, TOWN OR LOCATION OF		9c. COUNT	Y OF DEATH				
ō	Frederick Memori	Frederick Memorial Hospital Frederick Frederick									
DIRECTOR	Maryland Fre	v ederick		N OR LOCATION New Market		10d. INSIDE CITY LIMITS? 1 YES 2 NO					
FUNERAL	6722 Lake Ridge	Road		101. ZIP CODE 21.7	74	10g. CITIZE	10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	S. ARMED 2 XINO	3. WAS DECENDENT OF HISP If yes, specify Cuben, Mexi 1 TES 2 NO Spec	es or No — 14	14. RACE — American Indian, Black, White, etc. Specify: White						
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION o completed) College (1-4 or 5+)	Ille. Do NOT use retire	ne during most of working d.)	st of working						
OMP	17. FATHER'S NAME (First, Middle, Lest)	Ц	Para-lega		Law I						
ш	David A. Korn				iame (First, Middle, Maide in K. Palme	,					
TO B	19a. INFORMANT'S NAME (Type/Print)			ESS (Street and Number or Rura							
-	Dlenn I. Weigle			Ridge Road,							
	20e_METHOD OF DISPOSITION 1	cemete M	ACE AND DATE OF DISF	etery Feb.	27, 1993		erick, Maryland				
	21. SIGNATURE OF FUNERAL SERVICE LIKE	C. Basford	M00021	Keeney and I 106 East Chu	Basford Fur		Home .ck, Md. 21701				
	23. PART I. Enter the diseases, or shock, or heart failure.	complications that caused the	he deeth. Do not en				t, Approximate				
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	disease or condition SUB APACLANDIO HTMO(COLARE I MO NOVIDA									
NO	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	if arry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	cDUE TO (OR AS A CO									
AL CE	PART II. Other significant condition	is contributing to deeth but	not resulting in the	underlying ceuse given is	Part I. 24a, WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDINGS				
MEDICA						PRMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ОТН								
H	27. MANNER OF OEATH	28a. DATE OF INJURY	28b. TIME OF	28c. INJURY AT	lence 6 Other (Specify) 28d. 0E\$CRIBE HOW INJURY OCCUREO						
ВУ Б	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	M	WORK?							
ED	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, street, f	281. LOCATION (Stree City or Town, State	LOCATION (Street and Number or Rural Route Number, City or Town, State)						
OMPLET	cause(a) and manner as stated.										
BE CO	296. SIGNATURE AND TITLE OF CERTIFIES										
5	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED ONUSE OF DEATH	(ITEM 27) (Type, Print)	touse AVE	SUITE 3	305 P	REDERICK, MD				
	31. DATE FILED WATER 0 37 1993	32. REGISTRAR'S SIGNATU	IRE				9/01				



e retained by the hospital or attending physician.	e 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should		notified at once.
AL ON NITENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may b	min HETOP. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 shou	Process after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	it seems 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
TO THE HOSPITA	TO THE FUMERRY	be filed within 7	IMPORTANT: 1

1 1	EMS: IUb,c,d,e,	t, PER	F.H (G - 69	8 4 /	16/	93	t.t			9	13 09	000	
	1 - FOR STATE REGISTRAR	STATE OF MA		DEPAR					MENTAI	HYGIEN REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)									OF DEATH		3. TIME OF	F DEATH	
	FRANK RENE (March 16 199			3 7:	15 A M			
- 1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)	IF UNDE	1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH		BIRTHPLACE (State	te or Foreign	
- 4	216-14-3490	4-3490 1XXM 2□F 88			MONTHS	DAYS	HOURS	MIN.	Ma h	ch 1	1905 New Jersey			
	9a. FACILITY NAME (If not institution, give street and number)				9b. CITY	r, TOWN O	OR LOCATION OF DEATH			Cit i	9c. COUNTY OF DEATH			
E	Corsica Hills Nue		Co	ntre	Will	0			Ougon	Anno				
5	RESIDENCE OF DECEDENT	, –	1 06	noce	·			Queen Anne						
DIRECTOR	10a, STATE 10b, COUNTY AND AND	10c. CI1	Annapolis GRASON					ILLE		10d. INSID	E CITY S? 2 🖄 NO			
FUNERAL	100. STREET AND NUMBER 82 COVIDENCE Street	96A	A 21401 2 1				216	3 8		ed State				
2	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AF	ARMED 13. WAS DECEND							na or No.— 14. RACE — American Indian, Black, White, atc.			
BY	1 Never Married XX Married 3 Widowed 4 Divorced	FORCES? 1 [IF YES, GIVE WA	R OR DATES	1 YES			specify Cuban, Mexican, Puarto Rican, etc.) S 2 NO Specify:			, , , , , ,	Specify: White			
	15. DECEDENT'S EDUC	ATION	100 00	CEDENTY	EDENT'S USUAL OCCUPATION					VIND OF BUI	SINESS (IND. IS			
1	(Specify only highest grade of	completed)	(G	live kind of Do NOT u	work done	during mos	et of working	ng	100.	NIND OF BU	SINESS/INDUS	IHY		
7	Elementary/Secondary (0-12)	College (1-4 or 5+)		Stati			aina	04		Ctata	al Ma	ul and		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	<u> </u>	,	suun	Lona	ly Ln				Middle, Maiden		Maryland		
ö	Martin Weidmann										ieulat			
BE	19a. INFORMANT'S NAME (Type/Print)		10	h MAILIN	ADDRES	S (Street to								
2	198. INFORMANT'S NAME (Type/Print) 198. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard R. Weidmann 1057 Lido Drive Annapolis. Maryland 21401)1		
	20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name DATE 20c. LOCATION — City or Town, State													
	1 Device 2 Department of a Hemoval from State accommetary of other classes of the Chemotory 03-19-93 Brentwood, Maryland													
	21. SHONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home													
	147 Duke of Gloucester St. Annapolis, MD													
	23. PART 1. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cerdiec or respiratory arrest, Approximate													
	shock, or heart failure. List only one cause on each line.											rval Batween et end Death		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)											5	4 4-	
	resulting in death)	DUE TO (OR AS A CONSEQUENCE OF):							4		- 100			
-		Changie Koral Failur								e ys?				
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSE	QUENCE C	TUENCE OF):						5			
S	ceuse. Enter UNDERLYING CAUSE (Disease or Injury											705		
E	that initiated events	DUE TO (OR AS A CONSE		PFI:	1	1	T			1	:3,	Dun.	
	resulting in death) LAST (a g (olon (colos long) cured 30 %											100		
C	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													
8										PERFO	Sec. 1	COMPLETE	PRIOR TO ON OF CAUSE	
										1 TYES	NO	DF DEATH		
Σ		1 YES 2 NO											2 NO	
AN	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)													
[[]	EXAMINER?	EXAMINER? HOSPITAL: QTHER:												
PHYSICIAN: MEDICAL	27. MANNER OF DEATH	28s. DATE OF				JURY AT 28d. DESCRIBE HOW INJURY OCCURED					-			
	1 Natural 8 Pending	(Month, Day, Year)		IN	JURY	WO	28c. INJURY AT WORK? 1 YES 2 NO		200. SECONDE NOV MOUNT GOODIES					
В	2 Accident Investigation 3 Suicide 8 Could not be	street, fac				28f, LOC	281. LOCATION (Street and Number or Rural Route Number,							
3 Suicide 4 Homicide 5 Could not be detarmined 286. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data								or Town, State)					
E I	29a. CERTIFIER													
MP	CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. One) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.													
BE	296. SIGNATURE AND TITLE OF CERTIFIER	1/5		1	/			ENSE NUI				SIGNED (Month, De	y, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (TIEM 27) (TYDO PYNT)													

29d. DATE SIGNED (Month, Day, Year)

3-16-95

Centreville 16

